UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF NORTH CAROLINA

CHARLOTTE DIVISION

KANAUTICA ZAYRE-BROWN,)
Plaintiff)
)
vs.)
)
THE NORTH CAROLINA DEPARTMENT)
OF PUBLIC SAFETY, et al.)
Defendants)

DEPOSITION

OF

JOSEPH V. PENN, M.D.

August 8, 2023 - 9:12 A.M.

NORTH CAROLINA DEPARTMENT OF JUSTICE

114 WEST EDENTON STREET

RALEIGH, NORTH CAROLINA

PREPARED BY: Susan A. Hurrey, RPR
Discovery Court Reporters
and Legal Videographers, LLC
4208 Six Forks Road
Suite 1000
Raleigh, North Carolina 27609
919-424-8242
www.discoverydepo.com

CONTAINS GENERAL CONFIDENTIAL INFORMATION

A P P E A R A N C E S:

Plaintiff:

ACLU OF NORTH CAROLINA LEGAL FOUNDATIONS
P.O. Box 28004
Raleigh, North Carolina 27611-8004
919-834-3466
jmaffetore@acluofnc.org
Jaclyn A. Maffetore, Esquire,
Michele Delgado, Esquire, Dan Siegel,
Esquire, appearing

Defendant:

NORTH CAROLINA DEPARTMENT OF JUSTICE
114 West Edenton Street
Raleigh, North Carolina 27603
919-716-6516
orodriguez@ncdoj.gov
Orlando L. Rodriguez, Esquire and
Stephanie Brennan, Esquire, appearing

Also Present:

Jon Davidson (via Zoom)

I N D E X

E X A M I N A T I O N S

EXAMINATION	PAGE
Examination by Ms. Maffetore	4

E X H I B I T S

NUMBER	DESCRIPTION	PAGE
Ex-1	Expert Report of Dr. Penn	18
Ex-2	Curriculum Vitae	19
Ex-3	Policy Manual G-51.11	46
Ex-4	Press Release	54
Ex-5	Position Statement	60
Ex-6	Opinion - Jensen vs. Shinn	111
Ex-7	DAC 3421 - 3430	116
Ex-8	DAC 3404 - 3415	143
Ex-9	DAC 1182 - 1183	188
Ex-10	DAC 728 - 729	190
Ex-11	DAC 695 - 696	191
Ex-12	DAC 680	192
Ex-13	DAC 666 - 668	194
Ex-14	Affidavit of Dr. Penn	217
Ex-15	Penn-1 - Penn-11	224

JOSEPH V. PENN, M.D., having been first duly sworn, was examined and testified as follows:

BY MS. MAFFETORE:

Q. Good morning.

A. Good morning.

Q. My name is Jaclyn Maffetore. We just met a moment ago. I'm an attorney with the American Civil Liberties Union of North Carolina and I represent the plaintiff Ms. Kanautica Zayre-Brown in this case. Is it okay if I call you Dr. Penn as we move forward?

A. Yes.

Q. Can you please begin by stating and spelling your full name for the record?

A. Sure. Joseph Vincent Penn, M.D. It's J-o-s-e-p-h, Vincent is V-i-n-c-e-n-t, and Penn is P-e-n-n.

Q. Great. And so I just want to acknowledge for the record that since this lawsuit began, the North Carolina Department of Public Safety underwent an organizational transition. The prison division of that department is now called the Department of Adult Corrections and there's been a caption change in this case since the very beginning. For purposes of this deposition we might refer to the Department of Public Safety or the Department of Adult Corrections and by that we mean the same thing. So I just want to make sure that we are on the same page about that given that it was the North

Carolina Department of Public Safety or DPS when this lawsuit began. So if I say NCDPS, I mean what now exists as the North Carolina Department of Adult Corrections. Do you understand?

A. Yes.

Q. Great. Have you ever been deposed before?

A. Yes.

Q. Okay. Roughly how many times would you say?

A. I don't know the exact number. If I had to give a ballpark, 20.

Q. Okay. So while you're likely very familiar with deposition mechanics, I'm still going to lay some ground rules that I'm going to ask you to agree to just to ensure that the deposition goes as smoothly as possible, and so that we are operating on the same page as we move forward today.

Is that okay with you?

A. Sure.

Q. So first I ask that you answer each of my questions verbally as opposed to nodding your head or shaking your head or giving some other type of nonverbal response. Along the same lines, I ask that you try to answer any yes or no question with yes or no rather than uh-uh or uh-huh as those can be difficult for the court reporter to transcribe.

Do you agree to that?

A. Yes.

Q. So the court reporter, as you know, is taking

everything down, so I ask that you allow me to finish my question before you begin your answer and I will also do my best to allow you to finish your answer before I ask my next question. That's not natural for conversation, but it will make things easier for the court reporter and help ensure that we have a clean record. Do you agree to that?

A. Yes.

Q. Okay. And if you do not understand a question or need me to repeat it, please don't hesitate to let me know. But if you do answer my question, I will assume that you heard and understood it. Do you agree to that?

A. Yes.

Q. If you need a break at any point please let me know. While there will probably be natural breaking points in the deposition and either I or your counsel will suggest a break, if you feel like you need more water or a bathroom break please do let us know. I would just ask that if there's a question pending that you answer that question and then we can take a break. Do you agree to that?

A. You referred to him as my counsel and I'm not sure if he's my counsel or not. I'm a consultant to him. I don't believe I retained him.

Q. Sure. My understanding is that Orlando is representing you for the purposes of the deposition. Is that your understanding as well?

A. Mr. -- I'm sorry, go ahead.

MR. RODRIGUEZ: Yeah. So I'm defending the deposition of Dr. Penn. Yeah. So in that context that's what she means by the counsel or your counsel, not necessarily your privately-retained counsel.

THE WITNESS: Okay. Thanks for clarifying that. Yes.

MS. MAFFETORE: Great.

BY MS. MAFFETORE:

Q. So during the deposition, Mr. Rodriguez, acting as your counsel for the purposes of this deposition, might object to some of the questions that I ask. That is his right. But unless he specifically instructs you not to answer the question, you still need to answer the question. Do you understand?

A. Yes.

Q. Dr. Penn, the court reporter administered an oath to you earlier which you accented, meaning that you are under oath during the entirety of this deposition. It is the same oath you would take if you were testifying in a court room. You must testify truthfully and not leave anything out.

Do you understand and agree to that?

A. Yes.

Q. Is there any reason you cannot testify truthfully today?

A. No.

Q. Lastly, if you recall any additional information responsive to a question that I have asked at a later point during the deposition, I ask that you just let me know and we can go over what you feel that you have left out.

Do you agree to that?

A. Yes.

Q. Great. We can get started on real questions now, Dr. Penn. Did you talk to anybody beside the counsel in this matter for the defendant in order to prepare yourself to testify today?

A. Yes.

Q. Who was that?

A. And I'm so sorry, Attorney Stephanie --

MS. BRENNAN: Brennan.

THE WITNESS: Brennan. Yes.

BY MS. MAFFETORE:

Q. Is it your understanding that Ms. Brennan also represents the defendants in this matter?

A. Yes.

Q. Okay. And is there anybody other than counsel for the defendants that you spoke to to prepare for your deposition today?

A. No.

Q. Okay. Did you speak to -- or you did not speak to,

for example, Dr. Boyd, who is also a retained expert in this matter to prepare for the deposition today?

A. No.

Q. How about Dr. Li?

A. No.

Q. Did you speak with any of the defendants to prepare for this deposition today?

A. No.

Q. Did you review any documents to prepare for your deposition today?

A. Yes.

Q. Which documents are those?

A. I reviewed my initial declaration and my expert report. I also reviewed the declaration and expert report of your plaintiff -- your expert.

Q. Would that have been Dr. Randy Ettner?

A. Thank you, Dr. Randy Ettner. I'm going to refer to my report just to look at which documents I reviewed to prepare for the deposition.

(Pause.)

A. I read the Department's EMTO, the Evaluation for the Management and Treatment of Transgender Offenders, and the Department's policy titled Utilization Management, the position statement written by Dr. Campbell, the expert report of Dr. Boyd. I believe that's it. I may have reviewed some other

documents, but as we sit here today I don't recall all the other documents I reviewed to prepare for this deposition.

Q. Understood. Did you review any of Ms. Zayre-Brown's medical records in anticipation of this deposition today?

A. Yes.

Q. Did you review any of the rebuttal expert reports that were served on defendant's counsel yesterday before coming to this deposition today?

A. Yes. And if I could clarify my response. I did review Dr. Figler when you asked about medical records. Aside from the North Carolina Department of Corrections or DAC, I also reviewed the UNC health records, Dr. Figler. I think it's F-i-g-l-e-r. His evaluation of Ms. Brown. Mrs. Brown. Sorry.

Q. Sure. I asked you if you reviewed any of the rebuttal report. I want to be more specific. Did you review the rebuttal report prepared by Dr. Randy Ettner in anticipation of this deposition today?

A. Yes.

Q. Did you review the rebuttal report prepared by Dr. Antamaria in preparation for your deposition today?

A. No, I wasn't aware that -- sorry, let me clarify my response. I have not had a chance to review that rebuttal report.

Q. Understood. You mentioned that you reviewed the expert report of Dr. Boyd. Did you also review the expert

report of Dr. Li in preparation for today's deposition?

A. I think I skimmed it. I don't recall reading it in its entirety, but I did look at kind of the overall conclusions.

Q. Understood. Did you review any rough transcript or notes from the deposition of Dr. Boyd taken last week in this matter?

A. No.

Q. I apologize if I do that a couple of times throughout the deposition. I have a cough I can't get rid of.

Did you bring any documents with you to your deposition today? And I see that you have brought something there with you.

A. Yes.

Q. And what documents did you bring?

A. This is my expert report dated July 5, 2023.

Q. Have you made any notes in that copy of your expert report?

A. No.

Q. Other than what we have discussed so far, what else did you do to prepare for your deposition today?

A. I think that was it. I mentioned I may have skimmed some other documents. I did a continuing medical education course last Friday on intersex conditions and disorders of sexual development. But it wasn't for purposes -- it was more

just for continuing medical education. It wasn't necessarily preparing for this deposition. But the information that I gleaned from that is relevant to this case.

Q. Okay. And we'll come back to your training in just a little bit. But you said that that was on intersex conditions and disorders in sexual development, is that correct?

A. Yes.

Q. And you said that that was relevant to this case? That you did not take that CME for the purposes of this case, but that the content therein was relevant to this case?

A. It might be. It might be relevant.

Q. Dr. Penn, have you ever been sued before?

A. Yes.

Q. Okay. And how many times?

A. I think just one time. And to clarify, when you say sued, could you clarify how you're defining sued to be?

Q. Have you ever been named as a defendant in a lawsuit in other federal or state court?

A. Yes.

Q. You said just one time. Is that still your answer?

A. Yes.

Q. And when was that?

A. I don't recall the exact date.

Q. Approximately.

A. Maybe five years ago.

Q. Okay. What was the nature of that lawsuit?

A. Yes. It's regarding my capacity as the director of mental health services for the University of Texas medical branch, Correctional Managed Care division.

Q. What was the nature of the suit?

A. Yes. It had to do with gender dysphoria and items, personal items, accommodations for an individual who is incarcerated in the Texas prison testimony, the Texas Department of Criminal Justice.

Q. What were the allegations to you in that lawsuit?

A. I don't recall the specifics, but it was something to the effect that we had not -- sorry, when I say we, the University of Texas medical branch had not provided gender-affirming materials to this inmate.

Q. When you say materials, what were the accommodations being sought in that suit?

A. Sure. As I recall -- and this is the Hopkins case, H-o-p-k-i-n-s. Undergarments, makeup. I think that's it, undergarments and makeup.

Q. You said it's Hopkins. Do you recall, is it Hopkins versus --

A. Versus Collier, C-o-l-l-i-e-r. It might have been Livingston. He was the former executive director.

Q. Okay.

A. But basically the Texas Department of Criminal Justice

and UTMB Correctional Managed Care.

Q. Is that case ongoing?

A. Yes.

Q. Is there any other instance in which you were named as a defendant?

A. I was named in a case but then I was dropped from the case, so I don't know if I need to disclose that for purposes of litigation. I'm not currently a defendant in other cases that I'm aware of.

Q. You said you were initially named as a defendant in that case but you were dropped from the case?

A. Yes.

Q. What was that case?

A. That's the Haverkamp, H-a-v-e-r-k-a-m-p, versus Lannette Linthicum. That's L-a-n-n-e-t-t-e. Linthicum is L-i-n-t-h-i-c-u-m, M.D. and TDCJ.

Q. Okay. What was the nature of that case? Is that case ongoing?

A. It's ongoing.

Q. What is the nature of that case?

A. I don't know if I can talk about it because it's in active litigation right now. I was a 30(b)(6) witness for that case.

Q. When you were initially named in the complaint as a defendant, what were the allegations against you?

A. Well, there was nothing against me. It was against the University of Texas Medical Branch and TDCJ.

Q. What were those allegations?

A. It had to do with alleged failure to provide gender-affirming surgery.

Q. What is your understanding of why you were dropped from that lawsuit?

A. Because -- well, I really probably shouldn't talk about it because it's an ongoing case. It would be pure speculation. I don't understand the legalities of how I was dropped, to be honest.

Q. Are you aware of whether your dismissal from the case took place on the public court docket?

A. I don't know.

Q. Are you aware of whether that case is proceeding under seal?

A. I have no idea. I don't know if there's a protective order. I don't know. But I probably shouldn't talk about it because it's ongoing litigation.

Q. Are there any other lawsuits that we have not just discussed in which you were named as a defendant whether initially or throughout the entire litigation?

A. Not that I recall.

Q. Other than expert witness work or as a defendant, have you ever been involved in any other lawsuits?

A. Yes.

Q. In what capacity?

A. So I have testified as a 30(b)(6) witness several times for the Department, again for the University of Texas Medical Branch Correctional Managed Care on behalf of the Texas Department of Criminal Justice.

Q. And are those cases in which the Texas Department of Criminal Justice had been sued?

A. Yes.

Q. And so while as acting 30(b)(6) witness, you were a spokesperson for the defendant in that litigation, correct?

A. Correct.

Q. Is there any other context in which you have been involved in a lawsuit aside from acting as a 30(b)(6) witness, for a defendant, acting as a defendant yourself or acting as an expert?

A. Not that I recall as we sit here today.

Q. Okay. Approximately how many times would you say you have testified as a 30(b)(6) witness?

A. I think I have my list of testimony here. I would say -- if I can refer to it just to give a more accurate number --

Q. And just to be clear, you're looking at the list of testimony that's included as Exhibit B to your expert report which we will subsequently mark as an exhibit in this case?

A. Yes. Correct. And I neglected to mention, I have

testified before, not in a 30(b)(6) role, but when there's a criminal defendant in a county jail and they're being sentenced to the Texas Department of Criminal Justice, I have been asked to come in and testify regarding what provision of mental health and psychiatric services are available to that inmate should they be sent to the Texas Department of Criminal Justice. And I have done that probably three or four times.

Q. Okay.

A. To answer your question about 30(b)(6), I would say -- sorry, could you clarify the time frame for that? Because I'm looking at this for the last four years and I don't think I have done this except once. I have done it once in the last four years. I may have done it two or three times before that.

Q. I think that's sufficient for our purposes. And just for clarity's sake, for the record, I'm just going to go ahead and ask the court reporter to mark the expert report of Joseph W. Penn as Exhibit-1 in this case and you can continue to work from your copy, but I'm going to go ahead and have that marked as Exhibit-1.

A. And I'm so sorry, did you say W?

Q. Sorry, V.

A. V, right. V for Vincent. And I think there's a typo on one of the pages. It has it Joseph O, but it should be V.

Q. I happened to notice that.

- - -

(Document marked as Exhibit-1 for identification.)

- - -

BY MS. MAFFETORE:

Q. Dr. Penn, I'm going to refer to your expert report as Exhibit-1 moving forward. I don't know if you would like to write it on there or anything like that or if you just want to remember that your expert report moving forward is going to be Exhibit-1. But just for clarity's sake for the record, the list that you were just looking at was Appendix B to what has now been marked as Exhibit-1 to your expert report, which is a list of testimony, is that correct?

A. Correct. A list of my expert testimony, that's fair.

MR. RODRIGUEZ: For point of clarification, it's a list of expert testimony that's required to be disclosed by Rule 26a2VV, which is slightly different than just a list of expert testimony.

BY MS. MAFFETORE:

Q. And again, for the sake of clarity, in this list of testimony required to be disclosed, you have also included times when you have served or testified as a 30(b)(6) witness, correct? Or at least one time?

A. Well, so 2023 I served as a 30(b)(6) witness approximately two weeks ago.

Q. Okay.

A. And that was in the Haverkamp matter that I testified to earlier. So that's not reflected in this document.

Q. Understood. We'll talk about this a little bit more in-depth later. I just wanted to make sure we went ahead and marked it as an exhibit given that we are already talking about it now.

And just to make sure we put a bow on this, other than what we have just discussed, are there any other times that you have been involved in a lawsuit other than acting as an expert witness as a defendant, as a 30(b)(6) witness, or giving sort of qualification type of testimony that you just mentioned?

A. No.

Q. Okay. Great.

MS. MAFFETORE: So I'm just next going to hand the court reporter what we'll have marked as Exhibit-2, which is the C.V. that was filed in conjunction with defendant's response in opposition to plaintiff's motion for preliminary injunction at an earlier stage in this case.

- - -

(Document marked as Exhibit-2 for identification.)

- - -

BY MS. MAFFETORE:

Q. Dr. Penn, do you recognize this document?

A. Yes.

Q. Okay. And did you prepare this as a -- a C.V. on or about July 15, 2022 for submission in the defendant's materials in opposition to plaintiff's preliminary injunction in this case?

A. No. I would say -- I mean, I have a C.V. but it's kind of a work in progress because it gets outdated like on a weekly basis. But this is my C.V. as of that date. That's fair.

Q. You said it gets outdated on a weekly basis. Given that this was dated over a year ago, are there significant updates that you need to provide to this C.V. as we sit here today?

A. When you say significant, could you clarify so I can answer your question better?

Q. Updates of note that you think are important for us to know as we're sitting here for purposes of this deposition?

A. So yes, I would say some of the articles that were under review or in press have been published. I have given additional presentations. I would say I have been asked to serve on additional committees or in different capacities. But I would say in general this C.V. is pretty inclusive of my education, background and training to date.

Q. I can ask you about some of those more specific aspects as we go, if that would make more sense given the degree of updates that you seem to think are necessary to the

C.V. First, can you just walk me through your educational background?

A. Sure. So I got my undergraduate degree, a bachelor of science in biology at the University -- sorry, it was Incarnate Word College back then and now it's University of Incarnate Word. I received my medical degree at the University of Texas Medical Branch in Galveston, Texas. I did a four-year general psychiatry residency at Brown University in Providence, Rhode Island. I did a two-year child psychiatry fellowship at Brown University in Providence, Rhode Island. I did a one-year forensic psychiatry fellowship at Yale University in New Haven, Connecticut. So that's pretty much my undergrad, med school and postgraduate training. And then I have done CME and gone to conferences ad nauseam ever since.

Q. Sure. So while receiving -- we're speaking specifically about pre-graduate. While receiving your education, did you have any experience in the treatment of gender dysphoria or what was then known as gender-identity disorder?

A. Sorry, can you say it again, please?

Q. While receiving your education, did you get or did you have any experience in the treatment of gender dysphoria or what was then known as gender-identity disorder?

A. I don't recall specifics, but I believe during pediatrics rotation we got lectures about youth born with

ambiguous genitalia or intersex conditions. In my psychiatry residency training I did a lot of evaluations of individuals with para -- sorry, evaluations and treatment of individuals with paraphilias.

Q. Can you describe what you mean by paraphilias, please?

A. Sorry, I hadn't finished my answer to your question. I can answer paraphilias in a second. And then during my child psychiatry training I did evaluate several youth and adolescents that were referred that had gender confusion or they weren't certain they had been -- back then it was referred to as cross dressing or dressing in the other gender and the parents were concerned and brought them in for evaluation. So I have had experience in medical school and residency and fellowship. Sorry, to answer your question, paraphilias is a DSM mental disorder where individuals can engage in problematic behavior such as exposing themselves, transvestic fetishes, voyeurism, and other problems that are related to sexual behaviors.

Q. Okay. So I had asked you about experience in the treatment of gender dysphoria or gender-identity disorder. Is it your testimony today that the paraphilias you just described, that provides you with experience in the treatment of gender-identity disorder or gender dysphoria?

MR. RODRIGUEZ: Objection. Mischaracterization of testimony. You can answer.

BY MS. MAFFETORE:

Q. I'm not seeking to mischaracterize your testimony. I'm seeking to understand it.

A. What I was clarifying was a youth was referred for dressing -- either playing with dolls -- or let's say assigned male at birth, playing with dolls or acting more feminine and was dressing in female clothing, and they were referred for further evaluation, diagnosis and treatment. Similarly an adolescent might be referred -- a male adolescent or assigned male at birth and the dressing behaviors were identified as problematic. So yes, I did evaluations and management and treatment. And in some of those cases, like the adolescents and adults, I was asked to evaluate and I had to look in the differential whether there could be a gender dysphoria, back then gender-identity disorder, or whether it was a paraphilia or something else. So I had to consider all of that in the differential.

Q. Understood. So you also mentioned that you had pediatrics rotation, lectures related to youth born with ambiguous genitalia or intersex conditions. Is it your understanding that that is the profile of gender dysphoria or gender-identity disorder?

A. It's part of the differential. It's not necessarily -- as I understand it, the DSM-5 they included things to consider because some individuals could have gender dysphoria.

But it's another separate medical condition to consider in the differential and treatment of individuals with gender dysphoria.

Q. Understood. And you noted that you also treated individuals with gender confusion. Is that, in your opinion, the equivalent of gender dysphoria or gender-identity disorder?

A. Could you define gender -- how you're defining -- I don't recall about gender confusion. I was talking about the way they dressed, but I don't think I used the term gender confusion.

Q. My recollection -- and I don't know if the court reporter has the ability to read back -- is you testified when you were training in child psychology, people brought in their children as a result of cross dressing or gender confusion. Is that not your testimony today?

A. So I never trained in child psychology. I trained in child and adolescent psychiatry. But yes, I think some youth were brought to me under the general question about their sexuality or their gender. Yes, that's fair.

Q. And so in any of the evaluation contexts that you just discussed, did you have experience providing what is now commonly referred to as gender-affirming care to those patients?

A. Not at that time, no.

Q. So no experience providing or assisting patients

seeking specifically gender-affirming surgery?

A. Not during my residency and training, that's fair.

Q. Okay. How about during your post-graduate training? During that time did you have any experience in the treatment of gender dysphoria or what was then known as gender-identity disorder?

A. Sorry, could you clarify, during what time period, please?

Q. So when you were -- when we were speaking, you sort of distinguished between the time that you spent pre-fellowship and the time that you spent in fellowships. And so I guess what I mean by postgraduate training are those fellowships that you described to me. Unless what you just described to me was inclusive of those fellowships?

A. It was inclusive of those.

Q. Okay. Understood. So now I would like to turn to page nine of your C.V., which is Exhibit-2.

A. Page nine?

Q. Yes.

A. Okay.

Q. At the bottom of page nine is the beginning of a list of publications which carries over for several pages and appears to conclude on page 16. So first, the list of publications you have on page nine a header that states Publications, but then on page 11 you have a header that states

Other Peer-Reviewed Publications. Are the publications that are included under the heading entitled publications on page nine peer reviewed?

A. Yes, that's correct.

Q. Okay. So what is the purpose of the distinction between the publications category and the other peer-reviewed publications category, just for my understanding?

A. What I understand is like the article on Child and Adolescent Forensic Psychiatry, number three there, that underwent a review by the journal of Medicine and Health Rhode Island, but it wasn't a blinded where it was sent to like two peer -- I'm sorry, peer reviewers. It was pretty much published as-is without -- I mean, my peers were physicians, but I don't believe it underwent a child and adolescent forensic psychiatry review by a blinded review. And same thing with the other two abstracts, number one and two, those were presented at a conference. So they were reviewed by the education committee and they had the merit or the credibility to be presented at a conference, and then they were published in a journal. But they didn't undergo a separate peer review. So that's what I'm clarifying the peer review part there.

Q. Okay. Understood. Well, to make sure that I understand. Is your testimony that while these three articles included under Other Peer-Reviewed Publications were peer reviewed, they were not as vigorously peer reviewed as those

that you elected to included under the heading of Publications that begins on page?

A. Yes, that's fair.

Q. And so you have quite a few publications, but -- this is a general question. What are your general areas of research and writing?

A. So it's changed over time. I would say it used to be a lot more child and adolescent and juvenile corrections. But more recently it's been pretty much exclusively adult corrections, with some occasional juvenile corrections. And in particular issues of psychotropic medication use in correctional settings, suicide and special populations in correctional settings such as geriatric inmates and -- recently we have an article that we had an invited -- we were invited to write for you one of the journals on gender dysphoria in correctional settings.

Q. You said you were recently invited to write an article on gender dysphoria in correctional settings?

A. Yes.

Q. Who invited you to write that report?

A. The editor of the journal of Correctional Healthcare.

Q. When were you invited to write that article?

A. Approximately a year ago.

Q. Has that article been published?

A. No.

Q. What is its anticipated publication date?

A. So it's still in draft form.

Q. You said we were invited. With whom were you invited to write that article?

A. Well, sorry, I shouldn't say we. I was invited and given my time and other demands, I didn't think I could write it by myself so I reached out to two other colleagues. So that's what I was referring to as we.

Q. Who are those colleagues?

A. Sure. One is Nathaniel Morris, M-o-r-r-i-s, M.D., and the other is Joel, J-o-e-l, Andrade, A-n-d-r-a-d-e, Ph.D.

Q. You said that that article is still in draft form. What is the substance of the portion of the draft that you are responsible for writing?

A. Sorry, could you repeat that, please?

Q. What is the substance of the portion of the draft that you are responsible for writing?

A. Sure. So I'm kind of like the senior author reviewing the entire article in its entirety. But it has to do with evaluation, management and treatment of gender dysphoria -- sorry, transgender, individuals with or without gender dysphoria in correctional settings.

Q. Do you draw any conclusions in that report?

A. Did I draw any conclusions?

Q. Yes.

A. It's still in draft form. I would say that the themes are pretty consistent with the National Commission on Correctional Healthcare and the opinions that I have written in this case.

Q. Okay. Why did you select Dr. Nathaniel Morris, M.D. to assist you in drafting that article?

A. Sure. He goes by Ned. He is another correctional forensic psychiatrist and he works in jail settings, specifically San Francisco county jail and he's a prolific writer. He probably has written five times as much as I have. So he's a really good writer. So that's why -- in San Francisco obviously there's a large population. So I thought I could bring the prison focus and he could bring the jail focus to the article.

Q. Is Dr. Nathaniel Morris, M.D. experienced in writing on the topic of gender dysphoria or the treatment of transgender individuals with and without gender dysphoria?

A. I believe so. I think he has an article that he has published on that, yes.

Q. What about Dr. Joel Andrade?

A. Yes. Same thing. Joel is a -- he's a correctional mental health clinician. I think he's a social worker, but he also has a Ph.D. But he's been very active nationally in corrections, both jails and prisons. So I thought he -- and he's done a lot of trainings to correctional officers. So I

thought he would be another person that could really bring more of the education and training both of health care staff and correctional staff to this article.

Q. So you mentioned that you had additional publications since this C.V. was provided to us and I don't -- I won't ask you to provide to us every single one of those updated publications. Is there any publication that is missing from this list that you have provided to us that regards the treatment gender dysphoria?

A. No.

Q. Are there any peer-reviewed publications that are not contained in this list that you have provided to us that you feel are of particular note that your C.V. is fully incomplete without in your heart? Like one that is significant enough to you that want to make sure that it's updated for the record of this deposition?

A. No, not for purposes of this deposition.

Q. Understood. And so I asked you if you had any new publications related to the treatment of gender dysphoria. But have you ever published on the treatment of gender dysphoria?

A. No.

Q. Have you ever published on the provision of gender affirming care?

A. No.

Q. Have you ever published on the provision of

gender-affirming surgery specifically?

A. No.

Q. Okay. Have you ever published on the issue of treatment of trans prisoners generally?

A. Sorry, have I ever --

Q. The treatment of transgender prisoners generally.

A. Have I ever published?

Q. Published, yes, sir.

A. Yes.

Q. And what publication was this?

A. Sure. So one of the -- it's the American Psychiatric Association -- I'm not finding it here. Sorry. It's -- oh, here we go. I'm sorry. So it's the American Psychiatric Association. It's the psychiatric services -- item 21 on page 11. Psychiatric services in correctional facilities, third edition. So I was one of the authors of that. It's a little book. But it's a peer-reviewed publication. And it has -- it includes an entire section on LGTBQA and gender dysphoria inmates. Special populations.

Q. Okay. So your testimony is that item number 21 on page 11 has a chapter regarding LGTBQAI+ populations which includes the discussion of transgender prisoners, is that correct?

A. That's fair. Yes.

Q. Are there any other publications included here or not

included here that relate to the treatment of transgender prisoners generally?

A. I have written a couple of book chapters, but I don't recall as we sit here today if I discussed transgender or gender dysphoria. But once in the textbook of -- it's Kaplan and -- sorry, page 13, number 30. I don't know -- I don't recall as we sit here today if there's a separate section or language about transgender or gender dysphoria in that. But that's -- it's kind of like the book for psychiatry for medical students and residents is Kaplan and Sadoff, Comprehensive Textbook of Psychiatry, 10th edition.

Q. Item 21 on page with 11 that we were just discussing, were you the primary author of that chapter?

A. So the -- to answer your question, I have to clarify. People had assigned sections to write, but we all had input into the -- it was a consensus document. So I don't recall. I don't think I was -- I was not the lead in that section, but I did have input into the edits and final product. But no, I was not the lead author in that section.

Q. Did you take a lead role in authoring the portion related to transgender prisoners or did you just provide input as you discussed?

A. The latter, the input, yes.

Q. And we will return to your C.V., so keep that handy. But we're going to turn back to Exhibit-1, which is your expert

report. So I want to go ahead and ask you a couple of questions about the report generally. Did you draft this report?

A. Yes.

Q. Did anyone else assist you in drafting this report?

A. No.

Q. So the text in this report, you were the sole author of all text in this report?

A. Well, I think we have identified Mr. Orlando Rodriguez helped with the appendix, A and B. I think that's why there's a typo with my middle -- initial of my name. But other than that, everything -- the content in this all was submitted by me, except for the title of the appendix.

Q. Understood. Other than defendant's lawyers, did you speak to anybody about drafting this report?

A. No.

Q. So you did not speak to Dr. Sarah Boyd about drafting this report?

A. I have never spoken to Sarah Boyd. I wouldn't know her if she walked in the room today.

Q. And so you have also never spoken with Dr. Finley in preparation of your report?

A. Same. I have never spoken to her ever and I wouldn't know what she looked like if she walked in the room.

Q. Understood. And so exhibit A to this document is a

list of materials relied upon in drafting your report, correct? Sorry, appendix A.

A. I would say yes. But the two additional things I probably should have included or detailed were the psychometric testing that was administered by Dr. Ettner and also the psychometric testing that was administered by Dr. Boyd. I reviewed the actual raw data, if you will, and that's not detailed on this. But yes, otherwise those are the materials I reviewed.

Q. Okay. Other than those materials listed in a appendix A and the two that you just mentioned, the psychometric testing administered by Dr. Ettner and Boyd, are there any other documents that you have reviewed in preparing your report?

A. Dr. Li, she included like a -- several tables with her report. I don't know if that's called an exhibit or how that was referred to. So I didn't just read her expert report. I also reviewed her statistical analysis of the evidence research for the transgender studies. So it wasn't just her expert report, number 21. I also reviewed the tables that she prepared describing her research.

Q. Understood. Did you personally review all of the materials that you have listed in appendix A?

A. Yes.

Q. And what was your process for reviewing and relying on those materials?

A. Well, Mr. Orlando Rodriguez's office mailed the materials to me. Either hard copies or uploaded as a share file. And I basically read them and -- so that's how I did that.

Q. Did you take any notes on the materials?

A. Yes.

Q. What were you noting?

A. So I noted different things. For example, during the video deposition and Dr. Boyd's interview or evaluation of Mrs. Brown.

Q. Okay. Are those the only things that you made notes regarding in your material review?

A. Yes. I also took notes from phone calls with Orlando Rodriguez, phone calls with him.

Q. Okay. Understood. Did counsel instruct you to make any assumptions in preparing the report?

A. No.

Q. Other than the materials that we just discussed, did they provide you with any other information?

A. Yes.

Q. What was that information?

A. I understand that there's some new declaration or rebuttal report by a new expert. And I understand that there's some new information available regarding one of your experts that just became available as of yesterday.

Q. Understood. But to be clear, they did not provide you with any other information for the preparation of your report, correct?

A. No.

Q. Okay. So you have not spoken to Dr. Sarah Boyd or Dr. Li regarding this case ever? Was that your previous testimony?

A. Yes.

Q. Okay. So not only did you not speak to them in preparation of report, you have never spoken to them?

A. That's correct.

Q. So turning to your expert report on page two. You note at the top of page two, first full sentence, since 1999, I have focused my clinical, administrative, and forensic work primarily within correctional settings.

Did I read that correctly?

A. Yes.

Q. Where did you work prior to taking on your current role?

A. So I was an employee of Butler Hospital in Providence, Rhode Island from 1992 through 1996. And then I was an employee of Lifespan Hospitals in Providence, Rhode Island from 1996 through 1998. And then I was an employee of Yale University from 1998 through 1999. And then I was an employee of Lifespan hospitals from 1999 through 2008. And I have been an employee of the University of Texas Medical Branch from 2008

to the present.

Q. Understood. So your time with Butler Hospital in Rhode Island from 1992 to 1996, was that your time spent as a fellow?

A. So it was a resident, but I also did other things aside from being a resident.

Q. I'm just trying to ascertain whether it was a component of your education or -- so that was still a component of your educational requirements, correct?

A. Correct. But I was a licensed physician. So I was doing moonlighting, like doing competency evaluations at the county jail and doing other things like that.

Q. So your time spent at Butler Hospital in Rhode Island, was that work within the correctional setting?

A. I often went to -- like I said earlier, Rhode Island has a combined jail and prison system. So when I said county jail, that's correct. It's basically the Rhode Island Department of Corrections is the county jail/prison system.

Q. Did you do any work while at Butler Hospital that was not within the correctional setting?

A. Yes.

Q. And what was the nature of that work?

A. So I have worked across settings, both private psychiatric hospitals, state hospitals, the VA, veterans hospitals, HMOs, community mental health centers, emergency

rooms, children's psychiatric hospital, children's pediatric hospital, and other community hospitals with psychiatric units contained within the hospital. I'm probably forgetting, but that's kind of the extent of different places I have worked with -- worked in as part of my training.

Q. Sure. And so in 1996 and 1998 you said that you worked for Lifespan. Again, was that a component of your education?

A. Yes.

Q. So that would have been included in what we previously discussed as your experience during like postgraduate fellowship, is that right?

A. Correct.

Q. Was that in the correctional context?

A. So I did moonlighting. Again, like doing competency evaluations. I also did any kind of cases that involved special education or adults that were questioned about competency to stand trial. I did that as moonlighting during my training.

Q. Understood. How about your time at Yale? That was, again, within the context of your education and fellowship as we had previously discussed?

A. Yes.

Q. And was that in or outside of the correctional --

A. That was almost a hundred percent in correctional

settings. Going into county jails, doing competency evaluations, insanity defense evaluations, providing treatment to individuals in forensic -- correctional forensic units and other consultation.

Q. Okay. And I had asked you previously about your experience in the treatment of gender dysphoria or what was then known as gender-identity disorder and the experience that you recounted for me at that time would have included your time working at these three institutions, Butler Hospital, Lifespan Hospital and Yale?

A. Yes. That's fair.

Q. You also mentioned that from 1999 to 2008 you worked for Lifespan Hospital in Rhode Island, is that correct?

A. Yes.

Q. And was that work within the correctional setting?

A. Yes.

Q. Was it exclusively within the correctional setting?

A. No, it was -- I was halftime corrections and halftime outpatient.

Q. Did you treat any specific patient population in your time outpatient?

A. Yes.

Q. What was that patient population?

A. It was mainly children and adolescents and some adults with developmental disabilities.

Q. How about your -- in the portion that was corrections did you treat any specific patient population?

A. Yes.

Q. What was that?

A. It was incarcerated juveniles.

Q. Any other patient populations?

A. I consulted to several prison systems, Connecticut, Massachusetts and Rhode Island during that period of time also.

Q. Okay. And we will return to your consulting work. So while you were working with Lifespan from 1999 to 2008 did you have any experience in the treatment of gender dysphoria or with what was then known as gender-identity disorder?

A. I had some awareness, but I didn't have any firsthand involvement.

Q. Okay. And so is it safe to say then that you did not at that time have any experience treating patients any gender affirming care?

A. I mean, I treated a lot of patients for mental health, mental disorders. They may or may not have been undergoing gender affirming care or -- but I was focused more on the mental health treatment.

Q. Okay. So you did not treat anybody directly for the purposes of your treatment assisting the individual in receiving gender affirming care?

A. That's fair.

Q. So then nobody seeking gender-affirming surgery either then?

A. That's fair.

Q. Did the correctional system that you worked for from -- in association with Lifespan allow for the provision of gender-affirming surgery?

A. I don't recall. I don't think they had any policy or procedure regarding that specifically.

Q. Are you aware of whether anybody received gender-affirming surgery from that correctional system during your time working with them?

A. I don't believe so. I don't recall.

Q. So this is sort of a natural breaking point before we get into a big chunk. We have been going about an hour, if folks would like a break, but I'm also happy to keep going.

A. I'm good.

Q. You mentioned that you have been the director of mental health services for the UTMB Correctional Managed Care since 2008, correct?

A. Yes.

Q. I apologize in advance if I flummox those acronyms, but we'll try our best. Can you describe your responsibilities as the director of mental health services?

A. Sure. So it's really three different roles. The main role, I would say, is I oversee about 80 percent of the entire

Texas Department of Criminal Justice, the TDCJ, their state prison system, which includes juveniles and adults. So I oversee all of the mental health care from the time somebody hits the door to the time somebody leaves and the psychiatry, psychology and other mental health care. And then I'll say something about my gender dysphoria work at the end. But I oversee all of the psychiatric and mental health care for approximately 80 percent of the Texas prison system.

My other role is I oversee the psychiatric services that are provided to youth that are sent to the Texas Juvenile Justice Department, TJJD. And that's statewide. Similar to the TDCJ, which is statewide. TJJD is statewide. And then I oversee the psychiatric services to one county jail, Bexar County, it's B-e-x-a-r, San Antonio, Texas.

And then lastly, and probably most relevant to the purposes of today's deposition, is I oversee and have overseen all of the gender dysphoria and gender affirming evaluation, diagnosis and treatment systemwide within the whole state of Texas.

Q. Okay.

A. Sorry. I would say that's the main four things that I do, but occasionally I get asked to consult when we have really complicated patients that might be going, say, for bone marrow transplant off to a different hospital or other unique really high-profile cases. But I would say those are the four main

things. Those are the four main hats I wear.

Q. Okay. So you mentioned that UTMB CMC is responsible for providing care to prisoners in the Texas Department of Criminal Justice, correct?

A. Yes.

Q. And do you treat patients directly in your role?

A. Yes.

Q. How often do you do that?

A. It varies.

Q. On average how often would you say?

A. Well, when you say treat, maybe if you clarify. I'm involved in the evaluation and treatment of patients on a daily basis. What unit they should go to, if they're stable to be discharged, if they should be transferred to an emergency room, what medications they're on, approval of special medication. So that's how I would define treat.

Q. Sure. How often do you have clinical encounters with patients?

A. Again, it varies. I would say it depends on the patient and referral question. But it varies from week to week.

Q. Okay. What percentage of your time, I guess on an average week, would you say you spend in clinical encounters with patients, understanding that it varies from week to week?

A. Sure. 10 to 20 percent.

Q. Do you have clinical encounters specifically with patients in gender-affirming care for gender dysphoria?

A. Yes.

Q. And of that 10 to 20 percent of your time that you spend in clinical encounters on average with patients, how much of that time is spent specifically with patients seeking gender-affirming care for gender dysphoria?

A. That would probably be the bulk of the clinical work is overseeing directly the medications, approving and ordering the medications, because all of them are non-formulary medications, specifically the testosterone and other medications like that. Reviewing labs. So yeah, I would say 10 to 20 percent is a fair number.

Q. And so you just mentioned like seeking prescriptions, labs and things like that. What I'm talking about when I say clinical encounters is time spent in a room interfacing with a patient. What portion of your time would you say is spent actually having direct contact with a patient who is seeking gender-affirming care?

A. So during COVID we really backed off in-person encounters. We do more telemedicine. We have done telemedicine for about 15 years in our system.

Q. We'll call it face-to-face, how about that?

A. Sure. When you say face-to-face, I occasionally do go to prison units in person and see patients in person. But I

would say it's maybe five percent of the time.

Q. Okay. What about virtual face-to-face?

A. Well, I would include that. In person and virtual, like video conferencing, tele psychiatry, I would say about five percent.

Q. Is the provision of care through the UTMB CMC bound by TDCJ policies?

A. So I can't answer that with a yes or no. I would have to clarify my response.

Q. Okay.

A. So what UTMB Correctional Managed Care does is it's actually bound by statute. We have been doing this since like 1993, I think. When I say we, Texas Tech on the west end of the state and UTMB on the east part of the state. Texas Tech is about 20 percent of the patients, just males, that's all they have on the Texas Tech side. UTMB we have everything, male, female. So it's by -- it's codified in statute and the Correctional Managed Healthcare Committee is the overarching policy or -- like we have internal UTMB Correctional Managed Care policies, but those committees are joint committees between Texas Tech, UTMB and TDCJ. And those policies and procedures are vetted through and established under the Correctional Managed Healthcare committee as policies. Correctional Managed Healthcare policies.

Q. Okay. So to make sure I understand your testimony

correctly. UTMB CMC, Texas Tech, and TDCJ collaborate in the creation of the policies that bind treatment of patients who are within the custody of TDCJ?

A. So TDCJ has no clinical role. UTMB Correctional Managed Care, we provide all of the onsite care at all the prison units. We have a hundred prisons across the state and we do 80 of those and Texas Tech 20. We also provide all of the specialty care onsite or offsite, surgery, all that. We do all of that. UTMB handles that within our part of the state. TDCJ has a health services division, but they're more of a contract monitor and oversight and they handle grievances and patient or family complaints. So they don't do any direct patient delivery. All of the direct patient care delivery is done by UTMB Correctional Managed Care or Texas Tech.

Q. Okay.

MS. MAFFETORE: Now, I'm going to go hand the court reporter what I would be asked to be marked as Exhibit-3, and this might help us clarify this point a little built to make sure we're not talking past each other.

- - -

(Document marked as Exhibit-3 for identification.)

- - -

BY MS. MAFFETORE:

Q. Again, all of the ones with stickers on them the court

reporter will get back at the end of the day.

A. Of course.

Q. So I have just handed you a document which is titled Correctional Managed Health Care Policy Manual, policy number G-51.11, treatment of inmates with intersex conditions, or gender dysphoria, formerly known as gender identity disorder.

Do you recognize this document?

A. Yes.

Q. And so what entity is responsible for the creation of this document or entities?

A. So I can only testify to my knowledge from my having joined the organization in 2008. I believe there was already existing policy and I think at that time it was treatment of inmates with intersex conditions or gender identity disorder. So the entities would be UTMB Correctional Managed Care and me in working on that, Texas Tech, and the TDCJ Health Services through the joint -- sorry, joint gender dysphoria work group. That's how this policy would be reviewed and revised and updated would be through the joint gender dysphoria work group.

Q. Okay. And the Correctional Managed Healthcare policy manual, is that a policy manual held by TDCJ?

A. As I understand it, it's through the governor's office and it's something that TDCJ is bound to follow. So it's actually a step up higher. It's kind of like -- as I understand it it's what -- the state governor -- or the

governor and the state of Texas asks TDCJ to handle because -- yeah, so that's fair.

Q. You're familiar with this policy, correct?

A. Yes.

Q. Okay. Generally speaking, what is the purpose of this policy?

A. I'm sorry?

Q. The purpose of this policy?

A. Sure. So the purpose of this policy is this patient population is considered a special population and this is to provide clear guidance to explain the provision of how these individuals might be referred, evaluated, diagnosed and treated within a correctional setting.

Q. And that's for gender dysphoria, correct?

A. Well, it includes all three. It includes individuals who are transgender, individuals who might be transgender with or without gender dysphoria, and individuals that might have intersex or disorders of sexual development.

Q. Understood. Does this policy concerning the treatment of incarcerated persons with intersex conditions and gender dysphoria specifically allow for surgery as a treatment for gender dysphoria?

A. I understand the policy to not be prohibitive. It's moot on the issue. It doesn't say -- it doesn't say it's permissive, but it doesn't say it's not allowed or forbidden.

So it's moot on the issue.

Q. So the text of the policy makes no mention of surgical treatment for gender dysphoria, correct?

A. The current policy as written does not, that's fair.

Q. Understood. So keeping your report handy. At page three of your report, which is Exhibit-1 in this case, you note I also provided input and assisted with revisions to the State of Texas's Correctional Health Care Committee policy entitled Policy G-51.11 of the Correctional Managed Health Care Policy Manual, which concerns the treatment of incarcerated persons with intersex conditionals and gender dysphoria, correct?

A. Yes.

Q. Is that the same policy as we were just discussing in Exhibit-3?

A. Yes.

Q. Did you ever discuss including the provision of gender-affirming surgery in the time that you spent providing input and assistance with this policy?

A. I don't recall.

Q. Why wasn't the provision of gender-affirming surgery explicitly included in this policy?

MR. RODRIGUEZ: Objection. Speculation. You can answer.

THE WITNESS: So I don't know. I am part of the joint -- I'm actually the cochair of the joint gender

dysphoria work group. So that topic has not come up to date. It's not been raised as an agenda item to date.

BY MS. MAFFETORE:

Q. Have you ever sought to raise it as an agenda item?

A. Not to date, no.

Q. Based on your experience serving on this joint committee, is the provision of gender-affirming surgery a priority for the committee?

MR. RODRIGUEZ: Objection. Speculation. You can answer.

THE WITNESS: I'm sorry, it's not a committee. It's a work group. It's a work group. And I'm sorry, what was the question, please?

BY MS. MAFFETORE:

Q. Is the provision of gender-affirming surgery for the treatment of gender dysphoria a priority for the work group?

MR. RODRIGUEZ: Same objection. You can answer.

THE WITNESS: How would you define a priority?

BY MS. MAFFETORE

Q. Has it ever been discussed that it should be something that the health care system is doing for patients with gender dysphoria?

A. So I can't answer as a yes or no, but I can clarify -- I would have to explain my response. So in our system we have

the offender health care plan, which has language regarding what is considered covered benefit versus not covered. And if we had a patient that had imminent risks of harm, disfigurement, pain and suffering disability and other negative sequelae and was felt to be a surgical candidate, we would certainly review that patient's case and review the risks, benefits and alternatives of gender-affirming surgery if and when indicated.

Q. Has the system ever reviewed a request for gender-affirming surgery, to your knowledge?

A. I'm sorry, has the who? The question again, please.

Q. UTMB CMC.

A. So I'm not sure if I can answer the question because one of the cases, the Haverkamp case involves this issue and it's under current litigation, and it's the same issue about gender-affirming surgery.

Q. I'm sorry. And is that case under seal?

A. All I know is it's under current litigation and I probably shouldn't be talking about the specifics of that case because it's under a current litigation.

Q. Okay. And so I'm not asking you to disclose any HIPAA information or any information that would be, you know, private or specific to an individual patient. I'm asking you from a systems perspective whether the UTMB CMC has ever considered a request for gender-affirming surgical care for the treatment of

gender dysphoria.

A. Not to the best of my ability, no.

Q. Okay. And so pursuant to the policy that we have just discussed, gender-affirming surgery has never been considered under this policy as a gender-affirming treatment for an individual incarcerated in the Texas prison system who is seeking caring for gender dysphoria, is that correct?

MR. RODRIGUEZ: Object to the form. You can answer.

THE WITNESS: I didn't understand your question. Sorry.

BY MS. MAFFETORE:

Q. Following the procedures laid out in the policy we were just discussing at Exhibit-3, Policy G-51.11, no individual has ever been considered under this specific policy for gender-affirming surgery for the treatment of gender dysphoria, is that correct?

A. When you say considered, that's where I'm getting hung up. If you can clarify how you mean considered.

Q. Referred for treatment.

A. We have had one or two individuals self injure their penis and referred to the urology department on campus. Again, we're UTMB, they're UTMB. But as far as what -- to the best of my knowledge, and I can't get into specifics because of HIPAA, I believe they did a surgical repair. But I don't recall that

there was any further advancement of gender-affirming surgeries.

Q. So your understanding was that was a triage situation to resolve a medical emergency and not specifically for the treatment of an individual's gender dysphoria, is that correct?

A. Well, the surgery was done as an emergency surgery and the urology department did follow the patient. But once the patient was stabilized they were transferred to one of our inpatient psychiatric units and received further psychiatric evaluation and treatment. So I would consider that to be part of treatment for gender dysphoria. We didn't turn a blind eye to the fact that they had self-harmed. We did treat the patient and stabilize the patient. I think that occurred on two different occasions.

Q. So I'm asking was the surgery performed in that situation surgery for the specific purpose of treating an individual's gender dysphoria?

A. I believe it was more of a treating the acute emergency, rather than specifically for the gender dysphoria, that's fair.

Q. Understood. So in your role as mental health services director, you mentioned that you also oversee the provision of mental health services to those in the custody of the Texas Juvenile Justice Department, correct?

A. Yes.

Q. And you spoke a bit about your responsibilities in that role. Isn't it the case that the United States Department of Justice opened an investigation into the conditions of five juvenile facilities under the auspices of the TDJJ?

A. I'm sorry, the T -- what was that?

Q. Under the -- sorry. TDJJ.

A. Yes, that's fair.

Q. I'm now going to hand you --

A. Sorry, could you repeat the question again?

Q. Sure. Isn't the case that the United States Department of Justice opened an investigation into the conditions of five juvenile facilities within the TJJD?

A. Yes. Correct. It had nothing to do with medical or psychiatric care. It was strictly conditions of confinement. That's correct.

MS. MAFFETORE: I'd now like to hand you what I would ask the court reporter to mark as Exhibit-4.

- - -

(Document marked as Exhibit-4 for identification.)

- - -

BY MS. MAFFETORE:

Q. So the court reporter has just handed you what has been marked as Exhibit-4, which is a press release from the Department of Justice titled Justice Department Announces

Investigation into Conditions at Five Juvenile Facilities in Texas. Do you recognize this document?

A. No. I mean, this is the first time I have seen it, but I'm generally familiar with what the allegations are.

Q. Okay. So the second full paragraph on the first page of Exhibit-4 notes the investigation will also examine whether Texas provides adequate mental health care, is that correct?

A. Yes.

Q. And that would be in the context of the investigation into these five facilities under the under the jurisdiction of TJJD, correct?

MR. RODRIGUEZ: Objection. Lacks foundation. You can answer.

THE WITNESS: So to answer your question, I have to clarify that we -- my role, we don't have anything to do with the mental health care at the units. That's provided by TJJD. They have psychology staff and other staff that do the mental health care. My role, we oversee and I provide oversight of all the psychiatric care. So that's different. I have nothing really to do with the mental health care. My role is strictly the psychiatric care.

BY MS. MAFFETORE:

Q. Is psychiatric care considered mental health care?

A. It depends. In the purposes of the contract with TJJD between UTMB, it's spelled out explicitly that we provide

psychiatric care and TJJD provides mental health care.

Q. Does UTMB CMC collaborate with TJJD in the provision of psychiatric care to individuals incarcerated within TJJD?

A. Yes.

Q. To your understanding is that investigation ongoing?

MR. RODRIGUEZ: Objection. Lacks foundation. You can answer.

THE WITNESS: I have no -- I don't know anything about the status of it, if it's ongoing or what the -- I have never been interviewed so --- I would have thought if there was concerns about anything psychiatric I would have been directly interviewed, but I have not been interviewed to date. So the short answer to your question is I don't know the status of this.

BY MS. MAFFETORE:

Q. Are you aware of whether or not there have been inspections with respect to that investigation?

A. I'm generally aware, yes.

Q. Do you have any awareness of what those inspections have revealed?

A. No, I don't. I have not seen a report. Again, I was never interviewed by anyone that was on part of those inspection teams. I offered to meet with those folks and answer any questions that they had, but no one has come forward and asked any questions of me to date.

Q. Understood. And so if a patient within one of these five facilities was receiving not only psychology services but also psychiatric services, that patient would be a patient of the UTMB CMC, is that correct?

A. I'm not sure I understand your question. If you could --

Q. Sure. So you mentioned that the contract is very clear that TJJD provides mental health services, which I assume would be psychology services, but that UTMB CMC provides psychiatry services, is that correct?

A. Well -- okay. So we provide all health care. When someone comes into the facility they're seen by the nursing staff, their immunizations are checked, they're checked to see if they have any sexually transmitted diseases or any medical history or what medications they're on. If they're on psychotropic medications I would get called or one of our other staff. They would be seen by nursing. They have a physical -- so we handle all of the medical and -- if they cut or self-harm, we handle that. Psychology handles the counseling and therapy and psychology testing and the treatment teams of these youth and we're consultants -- I'm sorry, when I say we, UTMB Correctional Managed Care psychiatry are consultants to those treatment teams.

Q. So if an individual engages in self-harm, that's something you said that UTMB would be aware of?

A. If it's reported to us, yes.

Q. If an individual engages in suicide attempts, is that something that UTMB would be made aware of?

A. It's possible. Hopefully they notify us, yes.

Q. Are you aware of whether the investigation into these five facilities at TJJD have revealed significant suicide attempts?

A. When you say suicide attempt, if you could clarify how you're defining it so I can answer your question?

Q. An attempt by an individual to end their life.

A. So as I understand it, there have been investigations into self-harm and my understanding, my review of the data that's been presented, the majority of the self-harm was not necessarily near miss or lethal suicide attempts, it was just cutting or self-harm. So the question -- it's not clear if those were all suicide attempts or not or if they were non-suicidal, self-injurious behavior.

Q. Understood. You can set those aside. Again, referring back to your report. On page three you note and, I assisted in revising and approving, the NCCHC's 2020 position statement entitled: Transgender and Gender Diverse Health Care in Correctional Settings, is that correct?

A. Yes.

Q. What was your role in assisting in revising that position statement?

A. I'm a little foggy on the specifics. I have been on the NCCHC for like 20-plus years. What I understand is back then there was a policy and standards committee and the policy and standards committee reviews and updates or creates new position statements. And there was an existing position statement. And so it was scheduled to be reviewed and I was the only one that had correctional experience and direct patient care and administrative experience with this population. So they asked me -- the Policy and Standards Review committee asked me to review the document and provide input into that. So that's how I recall what happened.

Q. What input did you provide?

A. So I basically -- as I recall, I think it was sent to me and I did like the track changes and sent it back to the chair of the work group with my suggested edits. That's to the best of my recollection of how that worked.

Q. What changes did you suggest?

A. I don't recall the specifics. That was several years ago.

Q. Do you recall generally what changes you suggested?

A. No, not as we sit here today. I think I looked at the entire document. I do think that -- there was one section that I had direct -- that I can recall had to do with the adolescents. So I recall that I put in some wording or language regarding adolescents. I see it sitting there and I

would be happy to refer to that and explain to answer your question. But that's the one section that I distinctly recall because it was -- it didn't have any -- there was no language about adolescents. So that I think that was one of the main things that I contributed to the document.

Q. So aside from the piece that you recall regarding adolescents, you don't recall any input that you provided with respect to any other aspect of the NCCHC's policy statement?

A. I had some input into the evaluation and management and treatment sections also, but without the document I can't be more specific.

Q. Sure.

MS. MAFFETORE: I'm now going to hand the court reporter what will be marked as Exhibit-5, which is the position statement from the National Commission on Correctional Health Care, which we have been saying as NCCHC, entitled Transgender and Gender Diverse Health Care in Correctional Settings.

- - -

(Document marked as Exhibit-5 for identification.)

- - -

BY MS. MAFFETORE:

Q. Do you recognize this document?

A. Yes.

Q. And is this the position statement we were just discussing that you provided input on that is mentioned on page three of your expert report?

A. Yes.

Q. And does flipping through this document provide you with any refreshment of your recollection about any input that you provided to support your statement on page three of your report that you assisted in revising and approving this position statement?

A. Yes.

Q. And other than the adolescent piece you had just mentioned, what other input did you provide?

A. I believe I had some input in number six about looking for other mental health issues.

Q. Can you please direct me to the page that your --

A. I'm sorry, page three, number six.

Q. Okay.

A. And the point being that some of these individuals might not be readily identified and so health care staff should screen everyone who is incarcerated for mental health issues. In particular transgender patients and to look for comorbid conditions. And then I think I included number seven about psychotherapy and other mental health treatments, which is one of the main pillars, if you will, for this patient population. And then I think I added number eight also about hormone

medication treatment. And then candidacy for surgical interventions.

Q. So to the best of your recollection, you added that the clinical decision-making to initiate or advance hormone medication treatment or candidacy for surgical interventions while incarcerated or upon release needs to be based on individual medical need, risks and benefits, analysis of alternatives, ruling out contraindications, accepted standards of care, and a thorough informed-consent process?

A. I believe so, yes.

Q. And do you agree with that statement as articulated here in this final draft of this policy statement? Or sorry, position statement.

A. I'm sorry, I hadn't finished going through the things that I added or suggested be added to this document. Should I go through that and finish?

Q. So I appreciate if you can answer the question that I just asked and if there are additional things that you would like to follow up regarding the answer, that's fine.

A. Sure. And I'm sorry, what was the question, please?

Q. Do you agree with the number eight as it ultimately ended up in this final draft?

A. Yes.

Q. Are there any other aspects that you recall providing input on in this position statement?

A. I think number nine on page three about the pubertal suppression agents because again, getting at adolescents, there might be pre-pubertal or beginning puberty. And then I think I added nine B, B like boy, because sometimes we see this a lot in my clinical experience, a lot of patients come in and there's no way to figure out who actually was prescribing the hormones or if they were black market, you know, on the street. And same with C, nine C. And I think number 10. I don't think I added it, but I think I provided some language about a careful -- sorry, on page four, number 10. I think I added the language about a careful risk, benefit, and alternatives analysis.

Q. Just number 10 states evaluations to determine the medical necessity of gender-affirming surgical procedures will be performed on a case-by-case basis, applying a careful risk, benefits, and alternatives analysis. Gender-affirming procedures will be provided when determined to be medically necessary for a patient according to accepted medical standards, correct?

A. Yes.

Q. And your testimony is that you believe that you suggested the addition of applying a careful risk, benefit, and alternatives analysis?

A. Yes. And also medically necessary. I think I made some -- I think there was some language to that about surgical

procedures, gender-affirming surgical procedures, and I think I just added some language to make it more clear.

Q. And to the best of your understanding, is number 10 as we just discussed it consistent with the policy we discussed at Exhibit-3, G-51.11?

A. I'm sorry, say it again, please.

Q. Number 10, that criteria, we just discussed it. Is that consistent with the policy that we discussed as Exhibit-3, policy G-51.11?

A. So I think I testified to this earlier. Texas G-51.11 is moot on there is no document -- sorry, documentation around surgical procedures as I read that document.

Q. Okay. So in the prison system in which you predominantly work, the policy is silent as to whether or not it is compliant with number 10 from the NCCHC position statement, is that correct?

MR. RODRIGUEZ: Object to form. You can answer.

THE WITNESS: When you say compliant, I'm not sure I understand. We're not NCCHC in Texas so we wouldn't have to be compliant with this. The position statement is aspirational in nature. So we're not NCCHC in Texas.

BY MS. MAFFETORE:

Q. So Texas does not purport to incorporate this aspiration into its written policy, is that correct?

A. As I understand, Texas does not include that in their policy. That's fair.

Q. Okay. Thank you. Do you agree with the entirety of the NCCHC position statement?

MR. RODRIGUEZ: Object to the form. You can answer.

THE WITNESS: So I generally agree with the content of it, but it's -- with the caveat that; one, it's aspirational in nature; two, it's dependent upon a lot of different variables. For example, the duration that someone is going to be confined. If they're only going to be in a jail or prison for a few weeks or a few months, it would be hard to apply this -- sorry, would be difficult to apply this. And if there is some comorbid condition that hasn't been addressed or treated. Say, for example, an individual has had trauma, abuse and neglect may have posttraumatic stress disorder or some other mental disorder that hasn't been appropriately evaluated or treated. I would say I generally agree with this document, but there has to be other considerations on a case-by-case basis, and it has to include a multidisciplinary treatment approach to include health care and custody staff.

BY MS. MAFFETORE:

Q. Don't the aspects of this policy that we were just discussing incorporate evaluation on a case-by-case basis?

MR. RODRIGUEZ: Which policy?

MS. MAFFETORE: NCCHC position statement. Sorry.

THE WITNESS: So it's not really a policy. It's not -- there's no policy that I'm aware of that NCCHC has.

BY MS. MAFFETORE:

Q. Sorry, I intended to say position statement.

A. Okay. And I'm so sorry, what was the question, please?

Q. Doesn't it incorporate the evaluation should be performed on a case-by-case basis?

A. That's fair. I agree with that.

Q. And so are there other aspects of this position statement that you do not agree with?

A. No. I would just clarify that all this has to be considered within a correctional context and this document was predominantly written by health care staff, pediatricians, family doctors, nurses, psychiatrists, psychologists and others. I don't recall that there was much custody or correctional input and that always has to be at the table. So I would say that, again, this all has to be considered within a custody or correctional context.

Q. Understood. And again, NCCHC stands for National Commission on Correctional Health Care, correct?

A. Yes.

Q. So this was drafted with the intent that it would be

used in a correctional context, is that correct?

A. It's a position statement and it's aspirational. But as we sit here today I'm not -- I don't recall if any custody experts or custody staff were involved in this document revision or creation.

Q. Understood. But to the extent that is an aspirational document, it is aspirational for the custody content, correct?

A. That's fair. Yes.

Q. Okay. Thank you.

MS. MAFFETORE: So we have been going for about two hours. I think it's probably a good time to take a break before we jump into the next thing.

MR. RODRIGUEZ: Sure. 10 minutes.

- - -

(A break was taken, 10:59 a.m. - 11:11 a.m.)

- - -

BY MS. MAFFETORE:

Q. Dr. Penn, we are back on the record. Just a reminder that after that break we are -- you are still under oath. Understood?

A. Yes.

Q. Great. So turning back to your expert report, which is Exhibit-1. On page four you note that you oversaw -- wait for you to get there. Page four. At the top you note that you oversaw the development, implementation, and expansion of a

statewide specialized gender dysphoria referral and clinical program, is that correct?

A. Yes.

Q. When was that clinic established?

A. I don't recall the exact date. It would be a guess.

Q. What's your guess?

A. 2014/15.

Q. And when did you begin to oversee that clinic?

A. Again, I don't recall the exact date.

Q. Would it have been since its inception?

A. Yes.

Q. Is provision of health care at that clinic bound by the policy we have discussed as Exhibit-3, G-51.11?

A. I'm not sure I understand when you say bound.

Q. Is provision of health care at that clinic administered in accordance with that policy?

A. I would say generally speaking, yes. But in health care there's always exceptions and there's always unique patient cases. So I would say it's a framework, but I wouldn't agree that we're bound to it or we have to or must. We generally follow it.

Q. Okay. Does that clinic evaluate patients for the treatment of gender dysphoria through gender-affirming surgery?

A. Not -- no. No, we do not.

Q. Why not?

A. Well, in our system -- and again, our system is, as I mentioned earlier or testified to earlier, it's university based, systemwide, statewide. So if an individual, whether they had gender dysphoria or not, anyone that wants surgery it would go through the typical or standard utilization review process for a specialist consultation, specifically a surgery consultant. And so the gender dysphoria clinic, they're not surgeons so they wouldn't be involved in that. They would refer -- or any unit-based provider could refer for surgical consultation.

Q. Does the clinic evaluate patients for referrals to surgical consultations for gender-affirming surgery for the treatment of gender dysphoria?

A. Not to date, no. Not that I recall.

Q. Okay. Why not?

A. The majority of the treatment that's provided within the state of Texas to date is -- the gender-affirming treatment is hormone medication treatment and then there's some provision of additional gender-affirming items. But to date, surgery is not part of the gender dysphoria clinic program.

Q. Have individuals ever made a request to any provider of the gender dysphoria clinic program for a referral to a surgical consultant for gender-affirming surgery for the treatment of gender dysphoria?

A. Not that I'm aware of.

Q. So no patients at the gender dysphoria clinic has ever made a request for gender-affirming surgery?

A. Correct.

Q. Does the gender dysphoria clinic keep records of patients' requests for gender-affirming surgery that are made?

MR. RODRIGUEZ: Objection. Mischaracterization of previous testimony. You can answer.

THE WITNESS: So the short answer is no. Any patient chief complaint or sick call request would be scanned into the medical chart. Or alternatively if the patient went to the gender dysphoria clinic, their subjective complaint would be documented or memorialized in their evaluation, in their documentation. So that's how that would work.

BY MS. MAFFETORE:

Q. Has a patient ever reported to the gender dysphoria clinic where their chief subjective complaint was a request for gender-affirming surgery to treat their gender dysphoria?

MR. RODRIGUEZ: That's been answered. You can answer.

THE WITNESS: I think I answered that, that to date I don't recall any patients specifically seeking from a health care provider in the gender dysphoria clinic -- no one has requested surgery to date, to the best of my knowledge.

BY MS. MAFFETORE:

Q. Understood. And still on page four in the next

paragraph of your report you note that in total, I estimate that I have treated more than 1,500 incarcerated transgender patients with or without gender dysphoria.

Did I read that correctly?

A. Yes.

Q. What is that estimate based on?

A. So it's based on our caseload numbers. When we first started up the program I was one of the three psychiatrists that were seeing patients. I had a weekly clinic -- and actually, let me back up. When I first did my training with Dr. Walter Meyer I was going down to Galveston every week or every other week and seeing patients with him in person. Then when the volume grew I was seeing patients via telemedicine, video conference. And I have been involved -- I carried a caseload of patients that were predominantly Spanish speaking only because I'm fluent in Spanish. So I saw a lot of the patients that -- that way we didn't have to use a translator and I carried a caseload. And then more recently our caseload is about -- we have anywhere from five to 600 patients on the current caseload. So over the 10 years or 12 years, that's where I came to the 1,500.

BY MS. MAFFETORE:

Q. So are you including every patient that is on the caseload of the gender dysphoria clinic as a patient that you have seen in your estimate that you have treated more than

1,500 incarcerated transgender patients?

A. No.

Q. Okay. So I'm sorry to say that I don't quite understand how you arrived at the estimate of 1,500.

A. Sure. So the way that I came to that estimate and, again, it's an estimate, would be anyone that I had any handprint or footprint involvement with that patient, ordering medications, reviewing their labs, cosigning a note, ordering a non-formulary medication, doing a second opinion consultation, discussing the case with one of our gender dysphoria consultants or specialists. I would count that towards the 1,500 patients.

Q. Understood. So you mentioned tasks such as cosigning a note or ordering a non-formulary medication. Those are tasks that would not necessarily require you to have any interface with the patient, is that correct?

A. I would -- no -- sorry. I would say no, because I have to actually review the patient's chart and the medical record. So you're right, there wouldn't be a face to face, but there would be a review of the clinical information.

Q. Understood. How many patients would you estimate that you have had a face-to-face interaction with of the 1,500 incarcerated transgender patients that you have treated with or without gender dysphoria?

A. It would be a guess.

Q. Okay. What's your guess?

A. I don't -- I mean, as we sit here today I don't have my notes from clinics that I have held or dates. So it would be pure speculation. But I would say 500.

Q. So roughly a third of those folks?

A. That's fair.

Q. And you noted that these are transgender patients with or without gender dysphoria. How many transgender patients have you treated specifically for gender dysphoria?

A. I would say probably the majority of those have gender dysphoria. We have had some patients that don't meet the criteria for gender dysphoria. So that's why I was trying to be more clear in spelling that out. I would say the majority of patients that I see or evaluated or treated meet the DSM criteria for gender dysphoria.

Q. When you say majority, do you mean 751 or -- could you give me a rough percentage?

A. Sorry. Of the 1,500?

Q. Yes.

A. 1,400.

Q. How about of the roughly 500 that you might have seen in person?

A. 450.

Q. Thank you. And how many transgender patients have you treated who made any request for gender-affirming surgery?

A. Say that again, please. How many --

Q. How many patients, transgender patients have you treated who are seeking or had made a request for gender-affirming surgery?

A. Zero.

Q. Okay. And so you have not evaluated any patients of those 1,500 for gender affirming treatment for the treatment of gender dysphoria? Is that your testimony?

A. That's fair.

Q. Okay. And why have you not evaluated any patients for gender-affirming treatment for the treatment of gender dysphoria in your time at the gender dysphoria clinic?

MR. RODRIGUEZ: Objection. Asked and answered. You can answer.

THE WITNESS: Right. As I testified to earlier, in the clinic we're not surgeons so we don't have like a urologist or an ob-gyn as part of the clinic. So we strictly focus on making the diagnosis, looking at other comorbid diagnoses or conditions and then looking at the eligibility or contraindications to hormonal treatment. And in our experience the majority of the patients that we're treating, they're very satisfied with hormonal treatment and -- so that's the bulk of what the current treatment within Texas -- that's the provision of health care is gender-affirming hormonal treatment today.

BY MS. MAFFETORE:

Q. You stated that one of the reasons that you have not done any evaluation for referral for gender-affirming surgery is because you in the clinic are not surgeons, is that correct?

A. Correct. We don't have any surgeons, to the best of my knowledge, in the clinic. And two, on campus, UTMB, we don't have any, again, to the best of my knowledge, surgeons that are qualified or trained to do this kind of surgery. So we don't have that skill set, if you will.

Q. For any condition, does UTMB CMC ever refer people within TDCJ custody out to specialist surgeons in the community for the prevision of a surgical procedure that nobody within the UTMB CMC system is competent to provide?

A. As we sit here today, I don't know how to answer your question because I'm not privy to that data or information.

Q. Sitting here today, you do not know whether surgery is ever provided for people incarcerated within the TDCJ system outside of the context of UTMB CMC?

A. To the best of my knowledge and ability, patients that are referred for surgery, the surgery would occur at UTMB on campus. We're UTMB, they're UTMB. So we refer to the university and they have specialty surgeons for every kind of -- orthopedics, cardiovascular, thoracic. So all those would occur within UTMB so they would be internal. To the best of my knowledge as we sit here today, I don't know of any outside surgeries that have been referred to non-UTMB campus surgeons.

Q. Okay. And so to the best of your knowledge, UTMB CMC has a surgeon competent to provide all other care necessary within the TDCJ system?

MR. RODRIGUEZ: Objection to the form. You can answer.

THE WITNESS: I mean, we have surgeons that are board certified, trained, qualified across, you know, every type of surgery, urology, ob-gyn. And they don't just do TDCJ. They also do free world. So it's an academic teaching center probably similar to your UNC Health here. It's the same. It's tertiary where they refer more complicated patients and cases. So yes, they have the capacity, as I understand, pretty much to do every kind of surgery under the sun.

BY MS. MAFFETORE:

Q. Okay. But they do not have the capacity to perform gender-affirming surgery, I think was your testimony?

A. I think it was my testimony that I'm not aware of any current surgeons that have this specialized training or qualifications, to the best of my knowledge.

Q. Understood. So also at the bottom of page four, and you referred to this previously, you noted that you completed a specialized clinical training program regarding the evaluation and treatment of this patient population between December 2014 and December 2016 with Dr. Walter Meyer, is that correct?

A. Yes.

Q. Why did you seek that training with Dr. Meyer?

A. My supervisor, my boss identified that this patient population was a specialized patient population and he wanted me to get additional knowledge because we anticipated this population would grow in our system. And I also was interested in learning a lot more about this population. Also Dr. Meyer was in our backyard and he was one of the authors for WPATH and one of the pioneers in this treatment population. So I carved out time to go down to Galveston and see patients with Dr. Meyer, shadow him, meet with him additionally to discuss this patient population.

Q. Okay. And you note at the top of page five that Dr. Meyer is a respected international leader in transgender health care. What do you mean by that?

A. Well, as I testified to earlier, he was one of the first authors at WPATH. I think not just the most recent version seven -- I don't think he was in eight because he retired. But Dr. Meyer was one of the first people, as I recall, from Johns Hopkins to be involved -- he was a pediatrician and also an endocrinologist and then he went back and did adult psychiatry and child psychiatry. And he treated patients -- he's treated patients for decades of gender-affirming treatments. So he's one of the pioneers within endocrinology, to the best of my knowledge.

Q. So your statement that he's a respected international

leader in transgender health care in part has to do with his involvement in WPATH and the creation of the WPATH health care?

A. Well, I think he published and presented and lectured on this population. He was a contributor to WPATH. But I also think he also was in the publication for the endocrine society. It wasn't just WPATH. He also did other things too and he also published, I don't know, a hundred-plus articles. So he's basically very respected in the field.

Q. So he's involvement with the endocrine society is additionally something that you would point to that would make him well respected in the field, is that correct?

A. When you say well respected --

Q. A respected international leader in transgender health care, to use your words?

A. Yeah, I think that's fair.

Q. Understood. The fact that he has treated patients in this population for decades is also something that you would point to to note that he is a respected international leader in transgender health care?

A. Well, to clarify my response. Dr. Meyer was relatively new to treating inmates. He had never treated inmates. All his patients to date have been community, like outpatients. So part of my job was to help educate him to corrections and how our setting is very different from other settings. So to clarify my response, Dr. Meyer had tremendous

experience with treating this population in the community, but he didn't have any experience specifically within correctional settings.

Q. Okay. So my question was simply that part of the reason that you consider him a respected international leader in transgender health care is because he has treated patients who have gender dysphoria for decades, correct?

A. That's fair.

Q. Are you aware of whether he served on WPATH with plaintiff's expert Dr. Randy Ettner?

A. I recall seeing his name and maybe Dr. Ettner is author or something on the WPATH, SOC. Yes, for the seventh version, as I recall.

Q. Understood. Was your time training with Dr. Meyer a formal training program?

A. How would you define formal?

Q. Did you have to enroll in the program?

A. No.

Q. Were there any specific requirements to demonstrate competency?

A. No.

Q. Was there any certification offered as a result of the program?

A. No.

Q. Okay. So what was the nature of your time training

with Dr. Meyer?

A. Sure. So the nature was for me to read WPATH, read other articles that actually WPATH cited, to brush up on DSM -- it was four back then. And to shadow him seeing patients, actually doing physical examinations of patients that were transgendered, with or without gender dysphoria. Do psychiatric evaluations of these patients. Get informed consent and review medications, risks, benefits and alternatives. And to answer other questions for these patients. And then Dr. Meyer and I presented at a couple conferences together. We discussed some research initiatives or collaborations that we might consider doing. And I basically picked his brain. I tried to get his, you know, 50-year-plus experience with this population to try to learn as much as I could from him. So that's what -- how I would describe the training.

Q. You mentioned that you attended a couple of conferences together and did presentations together?

A. Correct.

Q. Are those presentations included in the presentations section of your C.V.?

A. Yes.

Q. I'm going to turn to that in a moment. And so in terms of the clinical experience of the training, would you categorize that as mostly shadowing Dr. Meyer?

A. No. I probably watched him do one or two patients -- or not do patients, but evaluate and assess and treat. And then I did several of my own and I would present the patient to him and discuss the patient. I would do the documentation on pretty much most of the patients we saw. So in the beginning, yes, I watched him see one or two patients, but for the most part it was like I was -- I wasn't just shadowing him. I was actually seeing patients and diagnosing and then presenting to Dr. Meyer to see if he agreed with my recommendations and management.

Q. I believe you mentioned previously that you were traveling to the clinic every week or every other week for a time, is that accurate?

A. Yes.

Q. For how long did you travel to the clinic for every week or every other week?

A. Sure. I have it here in my report on page four that I completed that training between December of 2014 and December of 2016. So that would have been the timeline.

Q. You testified previously that you were traveling to the clinic every week or every other week for a time. But then the patient load got significantly higher and then you had to transition to telehealth. I guess my question is at what point did you stop seeing patients in the clinic and transition predominantly to telehealth during that period of time?

A. I don't recall.

Q. Approximately how many cases would you say you shadowed before you began doing clinical evaluations on your own?

MR. RODRIGUEZ: Object to the form. You can answer.

THE WITNESS: I think I testified to that earlier. I watched Dr. Meyer see one or two patients and then from that point forward I did the psychiatric evaluation, and then Dr. Meyer would do the physical exam.

BY MS. MAFFETORE:

Q. Understood. And just to be clear, this was all in the same clinic that we were discussing that you stated in your report that you oversaw the development of, implementation of and expansion of, correct? The gender dysphoria referral program?

A. Not necessarily. This is just one component of that program.

Q. Okay. So the gender dysphoria clinic is just that -- where you received training, it's just one component of the program that you oversee in its entirety?

A. Correct.

Q. But while you were overseeing this program in its entirety from 2014 to 2016, you were being trained on gender dysphoria evaluation, is that correct?

MR. RODRIGUEZ: Objection to form. Mischaracterization of the report and prior testimony. You can answer.

THE WITNESS: It wasn't just evaluation. It was evaluation, diagnosis and treatment. And we -- because the population grew, we went from just university-based, in-person clinic, to incorporating telepsychiatry into this evaluation. And that was one of the things we presented on at a national conference, maybe two or three conferences. But we grew it. We expanded it from just a standalone clinic to utilizing telemedicine, telepsychiatry also.

BY MS. MAFFETORE:

Q. I understand. So I guess what I was trying to get at is you just testified a bit about your experience treating patients under this program, the overall program where you estimated that you had seen about 1500 patients. And you testified that during your time treating patients under that program, that you had not had any patients seeking gender-affirming surgery. And so I was just trying to understand if that includes your time working with Dr. Meyer at the gender dysphoria clinic.

MR. RODRIGUEZ: I'm going to object to the form and the characterization. Confusion between the testimony and the reports. You can answer.

MS. MAFFETORE: Sure. I can break it up. And

I apologize because I think breaking it up means I'm going ask you questions that you already answered. But I just want to be really clear so that we're not creating a confusing record.

BY MS. MAFFETORE:

Q. During your training with Dr. Meyer, did you evaluate any patients seeking gender-affirming surgery?

A. No.

Q. During your time training with Dr. Meyer at the gender dysphoria clinic, did you evaluate any patients that you ultimately referred to another provider for the provision of gender-affirming surgery?

A. No.

Q. If someone presented to the clinic seeking gender-affirming surgery, how did you and Dr. Meyer handle that request?

MR. RODRIGUEZ: Objection -- withdraw objection. You can answer.

THE WITNESS: So that would be hypothetical because no one asked for the surgery. But if someone had asked hypothetically for the surgery Dr. Meyer and I would have seen the patient, we would have spent -- probably done a deeper dive and a more detailed evaluation, maybe seeing the patient back two or three times. And then probably discussed it with my supervisor, Dr. Murray, and then that would have probably been referred similar to the North Carolina system where it

undergoes a multidisciplinary committee review. Dr. Murray, my boss, is a family physician. Dr. Linthicum, the TDCJ medical director, is an internal medicine. And then Dr. Deshields from Texas Tech is a family physician. So undergo a review by the joint medical directors. And then Dr. Linthicum would review with custody probably the correctional institution's department division director. So it would be very similar to how North Carolina does what they do where it would undergo additional multidisciplinary higher level review.

BY MS. MAFFETORE:

Q. But your testimony to date is that that is hypothetical because nobody has ever requested gender-affirming surgery at the gender dysphoria clinic, is that correct?

A. Correct.

Q. Does the gender dysphoria clinic keep records of requests made for gender-affirming surgery?

MR. RODRIGUEZ: Asked and answered. You can answer.

THE WITNESS: I'm trying to think. The short answer is no. We keep medical records and we keep lists of who's on the gender dysphoria caseload and who has a reminder to be rescheduled or followed up and what time frame. But we don't keep lists of who seeks what or who requests what. That would be beyond the scope of our health care utilization.

BY MS. MAFFETORE:

Q. Understood. You mentioned that you would evaluate -- after your shadowing period concluded that you would evaluate individuals, make your diagnosis and then present that to Dr. Meyer, is that correct?

A. So I would do a focus psychiatric evaluation and then a review of system of the DSM-5 criteria for gender dysphoria. And yes -- and then do a review of systems of any medical conditions or contraindications to hormonal treatment. And then yes, then I would present it to Dr. Meyer.

Q. Did you ever have any disagreements with Dr. Meyer?

A. No.

Q. You and Dr. Meyer were unanimous on each case that you presented back to him? Is that your testimony?

A. I'm not sure when you say unanimous how --

Q. You agreed on the correct course of treatment for each patient that you presented to Dr. Meyer is your testimony today?

A. I mean, it's possible there were some cases that I thought Dr. Meyer was being manipulated or patient was exaggerating symptoms. But he had much more experience in gender dysphoria, so I defer to his clinical knowledge. But as a forensic psychiatrist I'm trained in the assessment, evaluation and identification of malingering or exaggeration of deficits. But yes, I would defer to Dr. Meyer.

Q. Understood. Did you ever discuss with Dr. Meyer

whether or not the gender dysphoria clinic should evaluate patients for gender-affirming surgery?

A. No.

Q. Did you ever discuss with Dr. Meyer whether UTMB CMC should be providing transgender patients with gender dysphoria gender-affirming surgery?

A. No.

Q. Did Dr. Meyer ever express to you that he believed a patient seen at the clinic was a good candidate for gender-affirming surgery?

A. No.

Q. Did Dr. Meyer ever express to you that he believed gender-affirming surgery was medically necessary for any patients in the clinic?

A. No.

Q. You also noted on page five at the bottom of the paragraph that we were just referring to that subsequent to 2016 you continued your ongoing clinical collaboration and case discussion with Dr. Meyer up through his retirement a few years ago, is that correct?

A. Yes.

Q. Can you describe that collaboration?

A. Sure. So we had some more complicated patients that had different endocrine conditions. We also had some patients that were seeking testosterone because they were assigned --

assigned female at birth but identified as male, so trans males, who were seeking testosterone treatment. And I discussed medications and dosing and other things to watch for like risks -- issues of risk or concern with him. I think that's the main thing I discussed with Dr. Meyer subsequent to him departing in 2016.

Q. Okay. And how did you have discussions? Were they via phone, email, or other method?

A. I think the way we would do it, we would schedule a phone call and -- I don't recall emails. I think we mainly corresponded by telephone.

Q. How frequently would you say you collaborated with Dr. Meyer from the time between 2016 up through his retirement?

A. Pure speculation. Every couple of months. Once a year, once every couple of months.

Q. So your testimony is that you collaborated with Dr. Meyer every couple of months to once a year every year for six years after 2016, is that your testimony?

A. I think that's fair.

Q. After he left the clinic did you ever discuss an evaluation or recommendation of a patient for gender-affirming surgery?

A. Did I ever discuss...

Q. The evaluation or recommendation of a patient for gender-affirming surgery?

A. I don't recall.

Q. Other than your training with Dr. Meyer, have you received any other training in the treatment of gender dysphoria or the provision of gender affirming care that we have not already discussed?

A. Yes.

Q. What is that?

A. I don't recall the year, but I attended the course at the American Psychiatric Association that was specifically on transgender, gender dysphoria evaluation and treatment. And then I recently did one this past May in San Francisco at the American Psychiatric Association annual meeting. Same thing, on -- by panel presenters on gender dysphoria, evaluation and treatment. I have done some additional reading, but those are the main courses that I have done.

Q. So the first course that you discussed that you can't remember exactly when it took place offered by the -- I believe you said the American Psychiatric Association on gender dysphoria treatment, was that a continuing medical education course?

A. Yes. I had to pay for it. It was like a paid -- a separate course that they have offered there at the annual meeting.

Q. How long was that training?

A. It was an all-day training, eight hours.

Q. In the course of that training, did you receive any training on the evaluation of individuals for gender-affirming surgery for the treatment of gender dysphoria?

A. I don't recall.

Q. And in the May panel that you discussed also offered by the American Psychiatric Association in San Francisco, is that correct?

A. Yes.

Q. How long was that training?

A. I can't remember if it was an hour and a half, hour, two hours.

Q. And you described it as a panel, is that correct?

A. Right. There was like three different presenters. One of the individuals was actually transgender. And a treating -- I can't recall. I think one was a family physician, the other was a psychiatrist, and I forget who the third panelist was.

Q. Was that also a continuing medical education?

A. Yes.

Q. And in the course of that one-and-a-half to two-hour training, was there any training offered regarding the provision of gender-affirming surgery or evaluation for the provision of the gender affirming for the treatment gender dysphoria?

A. Yes.

Q. Can you describe the nature of that training?

A. They described, as I recall, the WPATH and the different criteria and how that was translated to the real world. But again, this was all community -- there was no mention of corrections or in carceral settings. It was just the provision of this evaluation and treatment within the community.

Q. So you mentioned that they discussed WPATH criteria. Were there any other criteria or standards of care that they relied on in giving that training?

A. They referred to the Endocrine Society regarding medications and treatments, as I recall.

Q. So also on page five in the next paragraph you noted that you have performed second opinion evaluations and consultations in other states, correct?

A. Yes.

Q. Have you ever provided a second opinion evaluation or a consultation regarding gender-affirming surgery in another state?

A. Yes.

Q. Have you ever recommended gender-affirming surgery in any of those evaluations or consultations?

A. I'm not sure if I can answer that question because it's HIPAA. It involves patient care.

Q. You don't have to give me any specifics. A yes or no

will do.

A. So yes, I did. I opined -- or I responded to the question and did indicate in my consultative note that the individual would have been a surgical candidate that -- met the criteria and would have been a candidate for surgery.

Q. Was that just in one instance or have there been multiple ones where that has taken place?

A. Again, I don't know if I can answer that question. I can recall one specific situation where yes, I did. But as we sit here today, I don't recall with the other states.

Q. Understood. And again, without disclosing any personal health information about a specific patient, what gender-affirming surgical procedure did you recommend?

A. I didn't recommend it, but I said that the individual was a surgical candidate for the sexual reassignment surgery now referred to as gender-affirming surgery. Bottom surgery or genital surgery.

Q. Okay. And which procedure was that?

A. It would have been a neo -- I can't remember if it was a neovulvoplasty or a neovaginoplasty.

Q. Again, without disclosing any personal health information regarding the patient at issue, when did you make that recommendation?

A. I don't recall the exact date. Somewhere like three, four years ago. I believe it was before COVID.

Q. When you say that you noted that that person was a candidate and met the criteria for that surgery, what criteria are you referring to?

A. So I said that the individual met the diagnostic criteria by DSM-5, was having significant distress, discomfort, impairments in their activities of daily living as required by DSM-5. And then I also referenced the WPATH Endocrine Society in my consultation.

Q. Okay. And you said that they met the criteria for the DSM-5. Are those the criteria for DSM-5 for gender dysphoria?

A. Yes.

Q. And just to be clear, was this consultation in the context of the prison system?

A. Yes.

Q. Okay. And in the prison system in which you gave this recommendation, did that prison system allow for gender-affirming surgery?

A. I don't know.

Q. Okay. You don't know if that prison system explicitly allowed for gender-affirming surgery in their written policies?

A. It don't know if they allow it and I don't know the status of where that is right now.

Q. You testified previously that you are not a surgeon, correct?

A. Correct.

Q. You testified previously that one of the reasons that the gender dysphoria clinic does not provide recommendations for gender-affirming surgery for the treatment gender dysphoria is because the gender dysphoria clinic does not employ any surgeons, correct?

A. That's correct.

Q. Why then did you provide a recommendation in your consultation capacity regarding whether or not an individual was a candidate for surgery for gender-affirming surgery in the treatment of gender dysphoria?

A. Because I was answering the question that was posed to me by the correctional health care entity that retained me to do this consultation.

Q. Understood. Have there been other situations where you have been asked to evaluate whether or not an individual was a candidate for gender-affirming surgery in your capacity as a consultant?

A. Yes.

Q. And for each of those you ultimately concluded that no, that person was not a candidate for surgery?

A. No, that's not correct.

Q. Okay. So there are other situations other than the one about which we were just discussing where you have concluded that a patient is a candidate for surgery?

A. So I can't get into the specifics because it's HIPAA

protected, but the case resolved -- I was retained. I was consulted specifically about gender-affirming surgery. But the patient's clinical situation changed and therefore there was no pending question for me to answer.

Q. Understood. So at the bottom of the same paragraph on page five, you note that you have presented nationally and internationally regarding the evaluation and diagnosis, clinical management, and treatment of transgender and gender diverse individuals within correctional settings, correct?

A. Yes.

Q. So I'd like to turn back to your C.V., which is Exhibit-1. I believe your presentations begin on page 16 and carry over to page 27. Sorry, I think I said your C.V. was Exhibit-1. It's actually Exhibit-2.

Do you have any updates to provide to your presentations which span from page 16 of Exhibit-2 to page 27 of Exhibit-2 that you think are especially relevant for purposes of this deposition as we sit here today?

A. Yes.

Q. And what is that?

A. So I need to update this. I don't have -- so I did a presentation on gender dysphoria within correctional settings with Joel Andrade. I don't recall the date or the conference. That's one. Number two, I gave a presentation a couple of months ago. The International Association of Correctional and

Forensic Psychologists and that was international. There were people from all over the world. It was a virtual CME or CEU program. I also did a presentation to, I believe it was Wexford in Colorado. I think it was in Denver. To all their health care staff. Both their medical and psychiatry and other health care staff a couple years ago. I don't recall the date.

Q. Okay. And so the first one that you said was a presentation on gender dysphoria in correctional settings with -- did you say Joel Andrade?

A. Sorry, Andrade, A-n-d-r-a-d-e. He's the one that I testified to earlier that we were writing an invited manuscript before --

Q. Understood. And you said you don't recall the date and the conference in which that presentation took place?

A. All I recall it was an NCCHC, a National Commission on Correctional Health Care conference. But I don't recall where it was or when it was.

Q. Do you recall whether it was after December of 2021, which is the latest presentation provided on your list of presentations?

A. It would be a guess. I think it was before COVID, but I could be wrong.

Q. Okay. Did you present at that time regarding the provision of gender-affirming surgery?

A. That was a topic that was discussed in the

presentation, yes.

Q. Did you present on that topic?

A. Yes.

Q. What did you say about the provision of gender-affirming surgery in your presentation?

A. So I think pretty much what I testified -- or sorry, what I wrote in my report here, which is that it has to be an individualized, case-by-case, that the literature supporting its use is very limited and lacks -- that there's limited evidence to support it. And that it has to be very carefully considered, particularly in the correctional setting. And again, individualized, case-by-case, multidisciplinary treatment team, risk, benefit analysis, alternatives, informed consent, looking for comorbid pathology and contraindications. So I included all of that in the presentation.

Q. Okay. And then the second one that you noted that is not included here, I think you said it was to the International Association of Correctional and Forensic Psychiatrists? Did I get that right?

A. Close. Psychologists.

Q. Psychologists. Okay. What was that presentation about?

A. I'm sorry, what was --

Q. What was that presentation about?

A. So as I understand, it was an invited presentation to

showcase how different states in the United States are grappling with the evaluation and treatment of gender dysphoria. I presented kind of the Texas model, and then my colleague Dr. Mehta, M-e-h-t-a, from California presented how California was addressing the current issue.

Q. Okay. Understood. You said that was a few months ago?

A. Maybe last year.

Q. Okay. And the presentation you gave you said at Wexford --

A. Yes.

Q. -- I believe? A few years ago?

A. Yes.

Q. Would that have been after December of 2021, which is the latest presentation date you have included in your list?

A. I don't recall the exact date. Sorry.

Q. And what was that presentation about?

A. It was an overall evaluation and management of inmates or -- incarcerated individuals with transgender and gender dysphoria. Maybe I said gender nonconforming, I think is the title of the presentation.

Q. And now I want to ask you about the ones that you have included in your report. And so the first of those is on page 26. It is item number 171. The Development of a University-Based Specialty Program for State Prisoners with

Gender Dysphoria. The American Correctional Association, 2016. Why were you asked to give this training?

A. As I understand Dr. Linthicum, our TDCJ medical director, she wanted us to showcase what we were doing at a national level at the American Correctional Association meeting. So she asked that we put together a presentation.

Q. And is this the presentation to which you're referring that you did with Dr. Meyer?

A. Yes.

Q. Okay. Did you discuss the provision of gender-affirming surgery at this presentation?

A. Did I?

Q. Yes.

A. No.

Q. Did Dr. Meyer?

A. I don't recall.

Q. Did anyone else?

A. I don't believe so.

Q. Okay. The next one is on the next page, page 27 of Exhibit-2. Item number 174. LGBT Offenders: Critical Issues in Gender Dysphoria at the National Institute of Corrections, 2016. Who were you asked to give this training?

A. I'm sorry, say it again, please.

Q. Why were you asked to give this presentation or training?

A. What I recall is -- I can't recall if it's Dr. Linthicum or someone else basically thought that this topic was very important, that many states were struggling -- sorry, states, when I refer to states I'm talking about departments of corrections and county jail also, large county jails were struggling with this issue. And so she encouraged me to -- I think the NIC, the National Institutes of Corrections, invited me and then I presented this talk.

Q. And this presentation, did this discuss the provision of gender-affirming surgery?

A. I believe so, yes.

Q. And did you discuss anything different than what you just described as having discussed at your presentation on gender dysphoria in the correctional setting with Joel Andrade?

A. No, I think it was pretty similar.

Q. And then number 183 on page 27 of Exhibit-2. Diagnosis and Treatment of Individuals with Gender Dysphoria (GD) within Correctional Settings, Developments in Correctional Psychiatry Course, American Psychiatry and the Law -- American Academy of Psychiatry and the Law, December of 2021.

Why were you asked to give this training?

A. Yeah. So as I recall the AAPL, the American Academy of Psychiatry and the Law is composed of forensic psychiatrists, but many forensic psychiatrists work in jails and prisons and we had done this course before, and it was felt

that there was a lot of emerging topics and new issues that needed to be reviewed and treatment approaches needed to be reviewed with psychiatrists that worked in these settings. So they specifically asked me to do the gender dysphoria portion over other topics, unrelated topics also. So that course was like a half day, if I'm not mistaken, four hours.

Q. Did you discuss the provision of gender-affirming surgery in this talk?

A. Yes.

Q. Did you discuss anything, aside from what you had previously discussed as included in your presentation on gender dysphoria and correctional settings with Dr. Joel Andrade?

A. I probably expanded more because the audience deals with legal systems, and I probably spent more time talking about landmark cases and how there's been diametrically opposed rulings in different states; Idaho, California, and Texas by way of example. So I basically described the different cases and how the courts have not really come to any one conclusion and how it has not been brought up to the U.S. Supreme Court to date. Again, I'm not a lawyer, but I spent time because the psychiatrists who do this do a lot of work with the legal system.

Q. Understood. Aside from these three presentations that are listed that we have just gone over and the other three that we discussed that are not included on this list, are there any

other presentations that I have overlooked that relate to gender dysphoria or the treatment gender dysphoria?

A. I don't believe so.

Q. Okay. Have you presented on how correctional systems can avoid legal liability in the provision of their health care services?

A. I think I presented -- or that's a topic area that I have discussed or presented, but I don't recall that being an entire lecture, unless if you can show that to me. I presented on that topic, but I don't recall a specific talk to that theme.

Q. Okay. But you recall that you have presented on that topic?

A. Yes.

Q. Do you recall if you have presented on how correctional systems can avoid legal liability, specifically in the provision of health care services with transgender individuals suffering from gender dysphoria?

A. No.

Q. Looking next to page eight of your C.V., which is Exhibit-3. So this is a portion of your C.V. that relates to committees that you have served on and I'm looking at the -- specifically at the state and local committees section. Under Texas Department of Criminal Justice, you have listed that from 2012 to 2017 you were involved in the Joint Gender Identity

Disorder Committee. And then lower down it says from 2017 to present Joint Gender Identity Disorder Committee cochair. Did I read that correctly?

A. Yes. I'm sorry, just to clarify, I think the committee has changed now from DSM-4 to DSM-5. It's no longer gender identity. It's now Gender Dysphoria Joint Work Group.

Q. Understood. So the term gender identity sort of was eliminated in 2013, correct?

A. Whenever -- policy changes can take a while. So I don't recall the specific date. But I think once we realized the DSM-4, the terminology had changed, I think that's when we updated the title of -- or the name of the committee.

Q. Okay. But the date on the C.V. that you have submitted is July 15, 2021, correct? And we can turn to the first page if you don't recall.

A. I'm sorry, July --

Q. 15, 2021 -- or sorry, 2022?

A. Right.

Q. As of July 15, 2022 was it still called the Joint Gender Identify Disorder Committee?

A. I don't believe so. I think it was the Joint Gender Dysphoria Work Group.

Q. And so this is a legacy item that had -- you neglected to update on your C.V. that it was called the Joint Gender Identity Disorder Committee?

A. That's fair.

Q. Okay. Do you recall approximately when the name change took place within the system?

A. Probably six months to a year after DSM changed from gender identity disorder to gender dysphoria.

Q. Understood. So now looking at page nine of your C.V., which is Exhibit-3 -- or Exhibit-2. Sorry. Under memberships and societies, you note that from 1987 to 1999 you were a member of the American Medical Association, and then again from 2002 to 2003 you were a member of the American Medical Association, is that correct?

A. Actually I need to update that. I'm currently a member. I apologize. I don't know when I reinstated my membership. But I'm a current American Medical Association member.

Q. Would you have reinstated your membership after submitting this version of your C.V. July 15, 2022?

A. I don't recall. All I know is -- it's been a couple of years. I'm going to say pre -- prior to submitting my report I was again a member of the AMA. And I would be happy to explain the reason why.

Q. That's okay. I just wanted to get that squared away. Are there any other committees that are not included or societies that are not included on this list that you are now a member of and you need to provide updates as to?

A. There probably are, but I -- with relevance to my academic and clinical work, probably not. I have gotten invited to some justice-related consortiums and some other thing -- it's like a judges and psychiatrists train the trainer thing. I guess at the end of the day I probably need to update my C.V.

Q. Understood. Thank you. So I now want to turn back to your report which is marked as Exhibit-1, and I want to look specifically at appendix B which we discussed a little bit previously, but that's appendix B to your expert report.

A. Sure.

Q. So this is a list of expert testimony for the last four years, correct?

A. Correct. And it doesn't include the one -- the 30(b)(6) witness case Haverkamp. That would have occurred this year.

Q. Are there any other updates that you need to provide to this list aside from the Haverkamp matter that we have already discussed?

A. Yes. I testified in Dallas County Court. I don't recall the name of the case, but it was a criminal trial and it was -- like I testified to earlier, it was an inmate who was going to be coming to the TDCJ, the Texas prison system, and I was asked to give testimony about the availability of different mental health services were that individual to come to TDCJ.

Q. Anything else?

A. I think that's it.

Q. Okay. In which of these cases did you provide expert testimony related to the treatment of gender dysphoria?

A. Well, the Haverkamp case that I testified just a second ago I was a 30(b)(6) witness and that case was regarding gender dysphoria and surgery.

Q. Understood. So the question that I'm asking you is in which cases did you provide expert testimony related to the provision of treatment for gender dysphoria?

A. Oh, sorry. I believe this is -- so none. I think this case here, the Kanautica Brown I think is the first case.

Q. So in none of these cases have you provided expert testimony regarding the provision of gender-affirming surgery, is that correct?

A. That's fair.

Q. Have you ever been qualified as an expert by any court in litigation involving the treatment of gender dysphoria?

A. No.

Q. And so never either about the provision of gender-affirming surgery?

A. No.

Q. Have you ever written a report in litigation involving the treatment of gender dysphoria for which you did not ultimately give testimony?

A. Yes.

Q. And what case was that?

A. So it's not listed here because I was not deposed at deposition or trial. But I have written -- I can't recall if they were declarations or -- I think they were declarations for the Raven, R-a-v-e-n, versus Colorado or Department of Corrections Colorado.

Q. And when was that?

A. Sorry, I'm trying to think if there's any others. I'm sorry, your question again was?

Q. Have you ever written a report in litigation involving the treatment of gender dysphoria for which you did not ultimately give testimony?

A. Yes. So aside from the Raven V Colorado, I was a consultant to the Moss Group, M-o-s-s Group, involving cis gendered women in the California prison system who had brought a suit against the California Department of Corrections and Rehabilitation. I provided input, but I wasn't the first author of that report.

Q. Okay. Again, the question was involving the treatment of gender dysphoria. Did that case pertain to the treatment of gender dysphoria?

A. Well, it had to do with housing. So yes, I would think that that would fall under gender dysphoria, the housing accommodations to transgendered inmates in female facilities,

yes.

Q. Understood. Okay. I thought that your testimony was that you were retained on behalf of a group of cis women?

A. No. No. I was a consultant for Moss Group. They were consulting to the California Attorney General's office because litigation had been brought forward by the cis -- by a group -- I think they had a class action and they were -- they brought a suit against trans females being moved in with the cis females. That's what I recall was the legal issue.

Q. Okay. So when was the Raven versus Colorado Case that you just mentioned?

A. That's ongoing.

Q. So have you not testified in that case because that case has not reached that stage in the litigation?

A. I don't know enough about where -- because it's ongoing I don't know if I should say anything. But I have not been asked to testify to date.

Q. Understood. And what did your report in that case involve?

A. What I understand was similar to this case, I was asked to comment upon or give opinions about the Colorado Department of Corrections, their policies and procedures regarding transgendered individuals with or without gender dysphoria who come into the Department of Corrections. I think that was the main question about that case. Policy review and

onsite review of their intake facility.

Q. And in that case were you asked to opine on the provision of gender-affirming surgery?

A. I don't believe so. I don't recall.

Q. Okay.

A. I don't think so, no.

Q. Were you asked to provide an evaluation of a specific individual or group of individuals seeking gender affirming care?

A. Yes.

Q. Okay. And what was the care that was being sought?

A. The named plaintiffs, they were, I think, like eight or nine and they were seeking class certification and I reviewed all of their medical records.

Q. And what was the gender-affirming care being sought?

A. I don't know if I can testify to that because it's HIPAA. It's their health care.

Q. Okay. Are you aware of whether the allegations in that case were filed under seal?

A. I'm sorry, if the allegations were --

Q. Filed under seal?

A. Yes. There's a protective order. I had to sign a protective order because of the health care records.

Q. Okay. Understood. In the case where you were a consultant to the Moss Group, when was that case?

A. Last year.

Q. Do you know the name of that case?

A. No.

Q. And what were you asked about or what were you asked to opine in that case?

A. What I recall was they were seeking my psychiatric expertise or knowledge regarding what type of review or evaluation should occur -- what kind of questions and steps the California Department of Corrections, CDCR, should utilize when considering a trans female to move from a male facility to a cis gender female facility, like cis female. Like a female facility. That's what I understood. It was coming up with criteria and questions of what should be looked at or identified.

Q. And were you asked to opine at all in that case regarding the provision of gender-affirming surgery?

A. I don't recall.

Q. Why didn't you ultimately testify in that case?

A. As I understand, I was a consultant to the Moss Group and the Moss Group wrote a report that they sent to the attorney general's office. I have no idea where that report went, if it was submitted or if it was just used internally for policy and procedure development. I don't -- as a consultant I just gave a recommendation and that's as far as it went.

Q. Understood. Have you either in any of the cases that

are included here or in older cases that would not be included here, have you ever been disqualified by a court as an expert witness?

A. No.

Q. Has a court ever held that your testimony was not credible?

A. No.

Q. Thank you. So your testimony today is that no court has ever held that your testimony is not credible?

A. That's correct.

Q. Okay.

MS. MAFFETORE: So I'm going to hand the court reporter what will be marked as Exhibit-6. This is very large so unfortunately I only have the one. I don't even have one for myself. So I'm going to hand this to the court reporter now.

- - -

(Document marked as Exhibit-6 for identification.)

- - -

BY MS. MAFFETORE:

Q. Dr. Penn, do you recognize Exhibit-6?

A. Yes.

Q. Okay. And what is Exhibit-6?

A. This looks like it's the opinion for the holding of

the judge in the Jensen V Shinn, S-h-i-n-n, case in Arizona.

Q. Thank you. And were you an expert for the defendants in Jensen versus Shinn?

A. Yes.

Q. Does this opinion -- or does flipping through this opinion refresh your recollection at all to whether or not a court has ever held that your testimony is not credible?

A. It refreshes my recollection, but as I testified earlier, court has never held that my opinion is not credible.

Q. So again, I apologize for the volume of this exhibit. I would like if you can turn with me to page 49 of Exhibit-6.

A. (Witness complies.)

Q. So looking at the top of page 49, the first full sentence on the first line. That line reads Dr. Penn's methodology is further flawed because his access to care standard does not carefully analyze if the care was medically acceptable. In essence, it was ambiguous, inconsistent and of no value.

Did I read that correctly?

A. Yes.

Q. And then if you look with me to the bottom of page 49, the last paragraph, second to last sentence. It states it is unclear whether Dr. Penn truly believed that not a single prisoner other than the one he discussed received deficient care or whether Dr. Penn believed he was hired to convey that

unsupported opinion. But, either way, that obstinance, and indifference, was devastating to his credibility and renders his opinion unworthy of any weight.

Did I read that correctly?

A. Yes.

Q. If you also turn with me to page 54.

A. (Witness complies.)

Q. The second to last paragraph states in general, Dr. Penn's testimony on the topic of language interpretation was unreliable and incredible.

Did I read that correctly?

A. Yes.

Q. And then finally, please turn with me to page 110 of Exhibit-6.

A. (Witness complies.)

Q. Note 28. States it is difficult to overstate Dr. Penn's lack of credibility. He was evasive when asked direct, simple questions. He failed to take a single note during his medical records review. His ignorance of fundamental aspects of defendants' health care system was obvious and his testimony contradicted the undisputed evidence at trial.

Did I read that correctly?

A. Yes.

Q. Does this refresh your recollection as to whether a court has ever held that your testimony was not credible?

A. Yes.

Q. Okay. Thank you. You can set that aside.

A. (Witness complies.)

Q. So turning to your expert report, Dr. Penn.

A. (Witness complies.)

Q. You stated that the expertise that you offered for --

A. I'm sorry, what page?

Q. I believe this is on the first page.

A. Thank you.

Q. On the expertise that you offered in this case, you have described as the provision of psychiatric, mental health and certain other medical and health care services across correctional settings, correct?

A. Yes.

Q. Do you purport to have expertise in the evaluation and treatment of gender dysphoria?

A. Yes.

Q. Okay. And what is that expertise based on?

A. Well, my medical education, my psychiatry residency and training and fellowship, my triple board certification in adult psychiatry, child and adolescent psychiatry and forensic psychiatry. And in my experience working in corrections 15 years in Texas and 10 years before in Rhode Island. All of that helps provide me the requisite knowledge and expertise in this field.

Q. Do you purport to have expertise in the evaluation and provision of gender-affirming surgery?

A. I don't have specific knowledge with regard to the exact surgical procedures. But my reading in the field helps guide me with -- to be able to weigh the risks, benefits, and alternatives and possible complications and contraindications as noted in Dr. Figler's document with Ms. Brown -- or Mrs. Brown, sorry. So even though I don't have requisite knowledge in the surgery, the technical part of it itself, I would say I have the knowledge and skill set and experience and training to evaluate who would be an appropriate candidate and who would not be an appropriate candidate for this type of surgery from a psychiatric perspective.

Q. Would you say you have expertise in the evaluation for gender-affirming surgery?

A. Yes.

Q. Okay. And what is that expertise based on?

A. That expertise is based, as I testified earlier, my background and training in general psychiatry, child, adolescent psychiatry and forensic psychiatry, my direct work in correctional settings and in forensic capacities since 1999. And my continuing education, attending conferences, discussion with other colleagues and review of the literature. That's what I would base it on.

Q. Okay.

MS. MAFFETORE: I'm now going to hand you what I will ask the court reporter to mark as Exhibit-7.

- - -

(Document marked as Exhibit-7 for identification.)

- - -

BY MS. MAFFETORE:

Q. Do you recognize Exhibit-7?

A. Yes.

Q. What is it?

A. This is the EMTO, Evaluation and Management of Transgender Offenders, as developed by the State of North Carolina, formerly the Department of Public Safety Prisons, now I believe it's referred to as the DAC, Department of Adult Corrections. And this is their policy, specifically F.4300 with regard to the evaluation and management of transgender offenders.

Q. So on page 10 of your report, you note in the first paragraph that based on your experience it is your opinion that the Department's policy comports with or exceeds what you would consider to be an acceptable standard for a comprehensive set of correctional health care protocols for transgender patients with gender dysphoria, is that correct?

A. Yes.

Q. And when you say the Department's policy, is Exhibit-7

the policy to which you're referring?

A. Yes.

Q. Why did you render this opinion in your report?

A. Because I was specifically asked -- that was one of the three things I was specifically asked to comment or address.

Q. What is your understanding of how that opinion relates to this case?

MR. RODRIGUEZ: I'm going to object. Speculation, legal opinion. But you can answer.

THE WITNESS: I have no idea. All I know is that's what I was -- Mr. Rodriguez and his office asked me to give them an opinion regarding.

BY MS. MAFFETORE:

Q. Is it your understanding that the plaintiff in this case is challenging this policy on its face?

A. I have no idea.

Q. When you say that you would -- that the Department's policy comports with or exceeds what you would consider to be an acceptable standard for a comprehensive set of correctional health care protocols, what do you mean by acceptable standard?

A. First of all, there's no published standards specific to gender -- sorry. Specific to transgender and gender dysphoria except things like PREA, Prison Rape Elimination Act, and other things, how to keep individuals that might be

transgender safe. The American Correctional Association does not have a specific policy on the evaluation and management of transgender or gender dysphoria inmates. And similarly NCCHC, all they have is the physician statement that we discussed earlier or I testified to earlier. But there's no set standard. And so my review of this policy in my professional opinion based on my evaluation, training and study, is that it does meet and exceeds what other health care systems in other similar sized states or larger states have promulgated for the evaluation, management of these patients.

Q. When you say that it comports with or exceeds an acceptable standard, you're referring to what other correctional systems across the country have done and that's what you're pointing to to determine what is an acceptable standard? Is that your testimony?

A. No. Sorry. What I testified to was there is no health care standard in NCCHC and there's no correctional standard in ACA. Looking at where the bar should be set from a correctional health perspective, looking at different states and large county jails, my professional opinion is that the North Carolina system meets or exceeds those safeguards, referral processes, multidisciplinary review, review of evidence-based protocols, all of that is how I came to that opinion that it's an acceptable standard.

Q. So an acceptable standard then is based on a review of

other systems and a review of protocols and a review of -- I'm trying to understand what you mean when you say here an acceptable standard. What is your acceptable standard that you are articulating when you say an acceptable standard in your report?

A. So what I'm referring to is what should be health care policy or procedure for referral, evaluation and management of a transgendered individual in a correctional setting. That's what I'm referring to as an acceptable standard.

Q. Okay. And so that is your subjective understanding of what constitutes an acceptable standard given your testimony that there is no nationwide set of standards?

A. No, I wouldn't say subjective standard. That's my -- again, I testified to this earlier. NCCHC -- looking at kind of the big three players, if you will, ACA, the American Correctional Association, NCCHC, the PREA standards, all of those -- and maybe even the Joint Commission if you want to throw that in there, looking at all of those established standards of corrections for correctional health, for national health care standards, that's the standards, the bar, if you will, where I'm opining that it's an acceptable standard. These correctional health care policies meet or exceed what a similarly sized state or county jail, that these meet or exceed that.

Q. Understood. Do you consider Texas's policy that we

discussed, Exhibit-3, to comport with an acceptable standard?

A. Yes.

Q. What is your understanding of whether the text of North Carolina's policy allows for gender-affirming surgery?

A. I'm sorry, I didn't understand the question.

Q. What is your understanding of whether the text of North Carolina's policy that we were just discussing, Exhibit-7, allows for gender-affirming surgery?

A. I'm so sorry, the text?

Q. The policy that's before you, what is your understanding of whether the plain text of that policy allows for the provision of gender-affirming surgery?

A. Yeah. So there's a process and it's documented in the procedures section, I believe, where they talk about the referral for a nonroutine -- sorry, let me make sure I get this right.

(Pause.)

A. Yes. Sorry. On page seven the division TARC, the Transgender Accommodation Review Committee, I think, is the acronym, they have specific language in here regarding nonroutine requests or accommodations and it's on page seven -- I don't know the exact number, but it's C for gender affirming surgical request. That's considered a nonroutine request. And then they detail the policy for how that would be referred through the facility TARC, T-A-R-C, all capital, and then the

division TARC, and then I believe there's a third layer where it's reviewed by the -- I'm sorry, I'm blanking on the name.

Q. That's okay. I'm going to ask you some specific questions about that in just a second so it's certainly not a memory test and we can get to that in just a second.

A. Okay. Thank you.

Q. So you note on page 11 of your report, back to Exhibit-1, your report, at the top, that the Department's review process as articulated in the policy relies on input from multiple clinical and nonclinical disciplines, correct?

A. Yes.

Q. Do you consider it appropriate for non-clinicians to consider and decide upon requests for surgical care?

A. Yes.

Q. Why?

A. Because this is all within a correctional context or correctional setting. And so regardless of what kind of surgery we're talking about, it could have programming, unit transfer, custody classification, housing, disciplinary -- there's a myriad of different custody or correctional things that are really nonclinical that would have all of those implications.

MR. RODRIGUEZ: Before your next question, we're passing lunchtime. I don't know -- I'm sure you have a good bit left.

MS. MAFFETORE: I have one more question before we sort of switch gears, so how about I finish up this line and we can take a break.

MR. RODRIGUEZ: That's works.

MS. MAFFETORE: Okay.

BY MS. MAFFETORE:

Q. So your testimony is that, yes, it is appropriate for nonclinicians to consider and decide requests for surgical care. Am I understanding that correctly?

A. No, that's not what I testified to. To clarify, having a multidisciplinary review is actually the best of both worlds because if you just have medical people or nursing or mental health with no custody you're working within a vacuum. So you really need custody at the table because of the issues I just testified to earlier about day-to-day programming, education, employment, showering, single cell versus having a cellmate, housing, custody classification, all those different processes, where they eat, where they recreate, all of those are relevant and that's why you need to have custody at the table. Custody is not going to opine on should they have the surgery, yes or no. But if and when an inmate has any kind of surgery, hip replacement surgery, back surgery, eye surgery, that has ramifications for custody and keeping that inmate safe while they're recovering from the surgery.

Q. Okay. Understood. So on page 12 of your report at

the bottom of the first full paragraph.

A. Sorry, page 12?

Q. Yes. This goes to some of the information that you were looking for in the policy. You note with respect to requests regarding surgical intervention or gender-identity consistent facility transfers, the recommendation of the Division TARC is referred to the Assistant Commissioner of Prisons and the Director of Health and Wellness Services for final review and determination.

Did I read that correctly?

A. Yes.

Q. So what is your understanding of whether the Assistant Commissioner of Prisons is a health care provider?

A. I'm so sorry, the Assistant Commissioner of Prisons?

Q. Yes?

A. Are they a health care provider?

Q. Yes.

A. I don't know. I don't know what the qualifications -- if you have a job description or minimum job qualifications I would be happy to answer your question. But I don't know if they are or are not a health care provider.

Q. So you have opined on the appropriateness of this policy without an understanding of whether or not one of the final two reviewers for gender-affirming surgery is or is not a clinician. Is that --

A. Sorry, that's not what I testified to. It's possible that the Assistant Commissioner of Prison -- my assumption is that they're probably a custody person. But it's possible and I have seen this before in my 30 years of corrections, where someone can be a custody person but they're also a social worker or a licensed professional counselor or some other health care provider. I would assume that the assistant commissioner is a non-clinician a non-health care provider. But, again -- what I understood at the time I wrote this report was that it was like the deputy commissioner. That's what I understand the term was and was not a clinician.

Q. Okay. So with the assumption that that role is not filled by a clinician, do you think it's an appropriate role for the assistant commissioner to opine on whether or not an individual should receive gender-affirming surgery?

MR. RODRIGUEZ: Objection. Mischaracterization of the report and the policy that it references. You can answer.

THE WITNESS: Correct. It's my understanding that the facility TARC, they do the initial and then it's reviewed. Because it's a non-routine request it goes to the division TARC and they ultimately make the recommendation of yes or no is the surgery appropriate, is it evidence based and all that. What I understand, my review of these documents and policies and procedures is that the assistant commissioner is

purely to make sure that custody did their due diligence, all the procedural things that they were supposed to do have been -- all the check boxes have been checked, if you will, from a custody perspective, PREA, ombudsman's office, safekeeping, custody and classification, they don't have any known enemies or other things that would affect their custody housing. That's my understanding of this with regard to the assistant commissioner.

BY MS. MAFFETORE:

Q. So my question is do you think it is an appropriate role for the assistant commissioner of Prisons to serve as a final reviewer and final determiner on questions of gender-affirming surgery? Yes or no?

A. Yes.

Q. Thank you.

MS. MAFFETORE: Now is a natural breaking point. So we can go off the record.

- - -

(Lunch break - 12:47 p.m. - 1:39 p.m.)

- - -

BY MS. MAFFETORE:

Q. Dr. Penn, we are back on the record after that lunch break and just a reminder after that longer break that you are still under oath. I'd like to turn now to page 19 of your report, which is Exhibit-1. At the bottom of the first full

paragraph on page 19 you note that the determination of medical necessity requires a patient-specific risk, benefit calculus and assessment of whether the proposed intervention has been demonstrated through vigorous medical research or other scientific evidence to be an effective treatment of the target condition.

Did I read that correctly?

A. Yes.

Q. In your opinion, what is a patient-specific risk, benefit calculus?

A. So for every health care condition, a child that has strep throat, you need to think about that the antibiotic you might prescribe for them could cause some acute allergic reaction and/or death. It could also cause drug resistance if you prescribe too much antibiotics for nonbacterial like viral infections. So everything in health care, whether it involves invasive diagnostic test, medication, or a surgery, you have to look at the risks, benefits and alternatives to the proposed intervention. And to review that with the patient to make sure that they're able to provide informed consent about the risks, benefits and alternatives.

Q. Okay. What does conducting a patient-specific risk, benefit calculus with that patient consist of?

A. So it would really be helpful for me if you could -- because there's so many different patient/doctor interactions,

if you could help me understand like are you referring to in this case gender-affirming surgery? Are you referring to medications? I'm having trouble getting my head around because I think of a lot of different things right now.

Q. Right. So I'm just trying to get at what you meant when you stated on page 19 of your report inherent in this determination is a patient-specific risk, benefit calculus.

A. Sure. So when I'm referring to patient, I'm referring to could be an outpatient, could be an inpatient, could be an incarcerated patient. There's different settings in which the patient might be. Whether the patient is going to stay short term, or long term. Like if the inmate were to be released in the next week or two or year, that's another thing you have to look at. The patient's compliance or cooperation with interventions. And if there's other possibly secondary gain or other intentional events outside of the health care focus. And then lastly from a purely health care issue would be the risks of pain, suffering, death, disfigurement, complications.

Q. What do you mean when you say secondary gain?

A. So within a correctional setting, one always needs to consider either faking good or faking bad or someone using health care or health care resources for a transfer under the guise of the health care reason for other purposes.

Q. And so you also state that it -- that medical necessity requires rigorous medical research or other

scientific evidence showing that it's an effective treatment of the target condition. In your opinion, what is required for medical research to be considered rigorous?

A. So what I would say is rigorous would be that it's -- we refer to, for example, a medication study or a vaccination or surgery, that it's evidence based, that it has been -- for example in a medication that it's been double lined, placebo controlled, that there's some gold standard methodology to show that it works. And rigorous means that because the implications are when you're talking about say gender-affirming surgery that's permanent and largely irreversible, you want to make sure that it's safe and that it's evidence based.

Q. What do you mean by evidence based?

A. So evidence based, my definition would be that there's been literature, clinical trials, randomized clinical trials, multisite as opposed to just anecdotal in my experience this works. Where you actually have proof, if you will, that's undergone clinical and research methodologies. That it's not just due to random, it's not just due to luck or chance. That the intervention truly does what it's supposed to do without causing bad outcomes or side effects.

Q. What is that opinion based on?

A. So it's based upon my education, training, experience and review of the literature.

Q. And so looking at the same sentence, you note to be an

effective treatment of the target condition. What do you mean when you say effective treatment in this context?

A. Well, effective would be that it either cures or ameliorates or reduces the pain or suffering or inflammation or distress.

Q. So something could be an effective treatment if it simply makes the symptom less severe?

A. I think I testified it could be curative. For example, if you have a bacterial infection, you have strep throat, if you get put on an antibiotic it should cure your strep throat infection.

Q. Understood. You stated that it either cures or ameliorates or reduces. So what I'm asking you is something considered an effective treatment if it simply makes a symptom less severe? Is that an effective treatment?

A. Well, it depends on how you identify effective. For example, the example that comes to mind immediately would be chemotherapy for cancer. That you can give someone chemotherapy or radiation or surgery, but it might have severe consequences and the treatment is worse than the original cancer and it could actually kill somebody. So effective has to do with again, that the intended effect of cure or relief outweighs the pain and suffering from the consequences of the treatment.

Q. So you said the intended effect of cure or relief

outweighs the pain and suffering of consequences of treatment, is that correct?

A. That's one hypothetical example, yes.

Q. Okay. In your opinion, what scientific evidence can demonstrate the efficacy of a treatment?

A. So it really depends. And I think in this particular case Dr. Li probably did the most detailed comparative effectiveness research looking at the literature specific to the main issue in this case of the gender surgery. But scientific evidence could be in some situations anecdotal. Like doctors haven't done a research study but they see an effect and it works, all the way to the most rigorous which would be like a double line, placebo-controlled study. Ideally multisite with randomization and done prospectively as opposed to retrospectively, that would really be the most rigorous type of research study and a large sample size. You have to have -- you just can't have one or two patients. You would want thousands of patients across multiple sites.

Q. So on page 20 of your report at the very top you note, I concur with Dr. Campbell's formulation of medical necessity in the context of reviewing and approving requests for medical services, correct?

A. Yes.

Q. But back on page 19 you note in the last paragraph on that page, that Dr. Campbell writes a medically necessary

procedure is one which is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain, correct?

A. Well, he writes that -- he gives a caveat. He says broadly speaking and then two, at the most basic level. So he kind of gives those two caveats.

Q. In your opinion, is gender dysphoria a serious medical need?

A. I would say it would depend. It could be and it could possibly not be.

Q. Okay. Do you know whether the Fourth Circuit Court of Appeals, the court of appeals under which North Carolina sits has held that gender dysphoria constitutes a serious medical need?

MR. RODRIGUEZ: Objection. Legal opinion. You can answer.

THE WITNESS: It would be presumptuous for me to give any kind of legal opinion or interpretation. I mean, I'll accept that that's what the court opined and I don't know the case or the facts or the issues in that particular case. But I'll accept that as fact if that's accurate.

BY MS. MAFFETORE:

Q. In your opinion, can gender dysphoria endanger someone's life?

A. When you say gender dysphoria, I think I know what

you're talking about but I would need more context of the clinical scenario. For example, a kid with strep throat, that could threaten their life. But it's not very common. So I just need to know more of the context of in which context of gender dysphoria are you referring to and what comorbidities. Is it just pure gender dysphoria or do they have some comorbid medical or psychiatric condition? Like do they have cancer? Do they have aplastic anemia? Do they have some other condition that could threaten their life?

Q. I'm speaking in generalities. In your opinion, have there been -- is it possible for gender dysphoria as that diagnosis, is it possible for gender dysphoria to rise to a level of severity such that it would threaten someone's life?

A. So I would say if there's comorbid untreated depression or another mental disorder that's not being treated, it is possible that someone could self-harm their genitalia or might engage in self-injury or self-harm or possibly a suicide attempt. But outside of those scenarios, I'm not aware of any other conditions where gender dysphoria would do something worse than that.

Q. So is it your testimony that somebody has to have a comorbid diagnosis of depression in order for a gender dysphoria to rise to the level of becoming life threatening?

MR. RODRIGUEZ: Objection. Mischaracterization of the testimony. You can answer.

THE WITNESS: No. What I was saying -- I was trying to answer your question because when you say gender dysphoria, that's nonspecific. And to date, the ICD-10 or 11 and gender -- sorry, the DSM, they have not quantified gender dysphoria into severity levels. So I would need more clarification on what has been done to evaluate, diagnose and treat the gender dysphoria, what's the clinical context, what other comorbid conditions are going on, what's the precipitant or stressor, what does the person have access to, do they have guns, do they have a lethal, meaning like clothing or something they could use to hang themselves. I would need to know the legal -- sorry, the clinical context to answer your question.

BY MS. MAFFETORE:

Q. Are you aware of whether individuals carrying a diagnosis of gender dysphoria alone have ever, in your experience, attempted self-mutilation?

A. Yes, I testified to that earlier. I think we have had at least two cases in Texas that I described earlier.

Q. And did you treat those individuals?

A. I didn't treat them directly, but I was involved in their treatment plan and where they were housed, and what services and evaluation they received subsequent to the self-harm.

Q. Are you aware of whether those individuals had been previously diagnosed with gender dysphoria?

A. I don't recall.

Q. Are you aware of whether they carried any other comorbid mental health conditions?

A. I would say in my experience, a majority of patients that I have seen it's the exception just to have gender dysphoria. The majority of the patients that I have seen or treated have multiple mental health comorbidities and multiple medical comorbidities. So it would be exceedingly rare for one just to have gender dysphoria alone in the correctional population that I'm used to treating.

Q. Can the distress associated with gender dysphoria result in a comorbid mental health condition?

A. I'm sorry, say it again, please.

Q. Can the distress associated with gender dysphoria result in a comorbid mental health condition?

A. Yes.

Q. Okay. In your opinion, can gender dysphoria rise to a level of severity to be considered significant illness or disability?

A. Yes.

Q. Can severe pain be mental or psychological?

A. I'm sorry, can severe pain --

Q. Be mental or psychological?

A. Yes.

Q. Can gender dysphoria cause severe pain?

A. How are you -- if you could clarify how you're defining severe pain. Because I think I know what you mean, but I would need to know if you're referring to physical pain, emotional pain or what kind of pain you're referring to.

Q. Can gender dysphoria cause severe mental or psychological pain?

A. Yes. And by the diagnostic criteria there has to be that experienced distress. Yes, that's fair.

Q. So does it follow then that if somebody carries a diagnosis for gender dysphoria they must be experiencing a clinically-significant level of distress?

A. Yes, to meet the DSM criteria there has to be a marked elevation in the distress due to what their experienced or expressed gender is from their perception of their self gender, and there has to be associated impairment in their activities of daily living and relationships and other levels of functioning.

Q. So also on page 19 you note that Dr. Campbell described some core components of medical necessity, the second of which he notes that the procedure has been determined to be the standard of care.

Did I read that correctly?

A. I'm so sorry, where are you, please?

Q. At the bottom of page 19 there's a sentence that has some numbers in it in parentheses.

A. Yes. Thank you.

Q. You said Dr. Campbell describes some core components of medical necessity, namely. And the second one that's listed there is that the procedure has been determined to be the standard of care, correct?

A. And again, I'm not an attorney, but my understanding of standard of care is a legal term and that's something that's used in the courts. And so a judge or jury would make a determination of -- you could pull in an expert to give opinions, but at the end of the day the factfinder would make a determination that the standard of care was met or if there was a deviation below the standard of care. So I'm not sure if I necessarily agree with Dr. Campbell on that specific point.

Q. Okay. So when you say on the following page, page 20, I concur with Dr. Campbell's formulation of medical necessity in the context of reviewing and approving requests for medical services, you are not saying that you concur with his stated belief that one of the core components of medical necessity is that the procedure has been determined to be the standard of care?

A. No, that's not what I testified to. You'll note I put quotation marks around standard of care to emphasize that I generally agree with that, that most interventions in medicine should be standard of care. But I was just making the clarification that the standard of care is a legal term and not

a medical term.

Q. And so when Dr. Campbell used the term standard of care he was using a legal term, is that your testimony?

MR. RODRIGUEZ: Objection, speculation. You can answer.

THE WITNESS: I don't know what Dr. Campbell was using. I think given what I understand Dr. Campbell's methodology was he was trying to come to a framework for what is the literature with regard to gender-affirming surgery in the entire, you know, universe, if you will. And so he was looking at literature, but he was also looking at it within the legal context. But again, this would be pure speculation. I never talked with Dr. Campbell. I don't understand why he used the term standard of care. But I generally do agree that if you're going to do an invasive procedure such as surgery, gender-affirming surgery, you probably want to do something that has been opined or determined to be the standard of care due to the risks involved.

BY MS. MAFFETORE:

Q. Understood. And like I said, I'm trying to fully understand what you mean when you say on page 20 that you concur with Dr. Campbell's formulation of medical necessity in the context of reviewing and approving requests for medical services. So my understanding of what you have laid out here on page 19 is what you understand to be his definition or

formulation of medical necessity, is that correct?

A. That's fair. I would put more weight and emphasis on the protecting life, preventing significant illness or disability, alleviating severe pain, more so than just the standard of care description there.

Q. So you agree with that portion more than the standard of care portion, is that your testimony?

A. Well, I would say I take all of them -- I don't know if I assign them weights. I would say they're all important.

Q. Okay. What is your understanding of the standard of care for the treatment of gender dysphoria?

A. So my understanding, as I have listed in my report, the entire third section where I refer to my review of the literature, my reading of Dr. Li's report and her independent review of the literature, is that the current literature is mixed and contradictory and thus, necessitates what North Carolina is doing, which they're looking at on a case-by-case basis. They're looking for that risk, benefit analysis. They're looking to ensure protecting life and preventing disability or illness and alleviating severe pain. So that would be my opinion.

Q. So that's your opinion on your understanding of the standard of care for the treatment of gender dysphoria?

A. Well, again, the empirical research that's been done, the qualitative research is mixed and the studies in particular

for long-term outcomes of gender-affirming surgery are mixed, at best.

Q. Are you aware of any authoritative standard of care for the treatment of gender dysphoria?

A. I understand that WPATH has created a document that they have titled standards of care, SOC. But I don't hold that to be a standard of care, nor authoritative with respect to this patient population.

Q. Do you consider WPATH to be reputable?

A. How do you define reputable, please?

Q. Worthy of respect in consideration of the appropriateness of treatment for individuals, trustworthy, evidence based?

A. So I think I put in my report and I do recall reading it in Dr. Boyd's report. I think the goals of WPATH are admirable. They're trying to advocate for transgender and gender nonconforming individuals to try to get them health care needs and services they need and all that. But there appear to be several issues that call into question if they're more a deliberate, specific medical and mental health organization that's strictly evidence based versus more of an advocacy group or alternatively, if members that have written any of the WPATH SOC, the standards of care, might have conflicts of interest from their litigation work or their clinical work. So those are some of the concerns that I have that would answer your

question about reputable or reputability, if that's a word.

Q. We'll talk a little bit more specifically about WPATH later. Are you aware of any other standard of care for the provision of treatment for gender dysphoria or gender-affirming surgery?

A. So I understand the Endocrine Society has some guidelines, but they're not -- to the best of my knowledge they're not -- they have not been determined to be standards of care or promulgated as standards of care. Those are the two main things that I'm aware of, the WPATH SOC and the Endocrine Society.

Q. Do you consider the Endocrine Society reputable?

A. So I would say the Endocrine Society, as I understand it, is comprised of mainly endocrinologists. So it's much more of a medical group. As we sit here today, I haven't looked at the Endocrine Society's documents or the composition of the people that wrote the Endocrine Society guidelines. And so I can't comment -- or I don't have an opinion today because I don't know, one, the members of the Endocrine Society document; and two, if they had any potential conflicts or if they're largely plaintiffs' expert sort of work. I think that would be an important thing to take into consideration also.

Q. What do you mean by largely plaintiffs' expert sort of work?

A. There are some individuals in my experience within --

I'll say within correctional settings that pretty much just do plaintiffs' expert work. They're not balanced. They don't do both. So that's what I was referring to as plaintiffs' expert work.

Q. Do you consider yourself as doing mostly defendants' expert work?

A. So I don't do either. When I come into a case I'm neutral. I'm objective and I strive for objectivity. I don't seek out cases. It's all word of mouth. I don't have a Website. I have done plaintiffs' work. I have done defense work. And as noted in my report, I have also been a qualified expert by the court in criminal and civil cases. So I try to be balanced. So I don't consider myself plaintiff's expert or plaintiff's defense. I consider myself to be as neutral and objective as possible whenever I'm looking at a new case.

Q. Are you a defense expert in this case?

A. Yes.

Q. Were you a defense expert in Jensen versus Shinn?

A. I'm sorry, say it again. Which case?

Q. Jensen versus Shinn.

A. Yes.

Q. Are you the defense expert in Raven versus Colorado?

A. Yes.

Q. Your concurrence with Dr. Campbell, as we discussed on the top of page 20, is in the context of reviewing and

approving requests for medical services. Are there other contexts in which you do not concur with Dr. Campbell's formulation of medical necessity?

A. Sorry. Page 20?

Q. Yes. The top of page 20 you note, I concur with Dr. Campbell's formulation of medical necessity in the context of reviewing and approving requests for medical services.

Are there contexts in which you do not concur with Dr. Campbell's formulation of medical necessity?

A. Well, in an emergency situation. If someone was acutely psychotic or acutely suicidal or imminent risk of harm to self or others, you don't have time to submit and review and approve those kind of requests. You manage the emergency then and there just like in an emergency room situation. So I would say that would -- I'm not disagreeing with Dr. Campbell. I'm just saying -- you asked me the question, so I'm just trying to be very precise in answering your question. But I would say an emergency you don't have the time for all this conditional review.

Q. Are there any other contexts in which you do not agree or concur with Dr. Campbell's formulation of medical necessity?

A. No.

Q. Okay.

MS. MAFFETORE: I would like to now hand the court reporter what is going to be marked as Exhibit-8.

- - -

(Document marked as Exhibit-8 for identification.)

- - -

BY MS. MAFFETORE:

Q. Have you seen Exhibit-8 before?

A. Yes.

Q. What is it?

A. My understanding is this is a document that Dr. Campbell, Arthur Campbell, the chief medical officer, medical director for the North Carolina Prison System, that he created this document based on a review of several articles that he reviewed.

Q. And what do you understand this document to be?

A. That's right. And not articles, but he also referred to a couple of -- at least one legal ruling on page 12 of the document. I'm sorry, what was the question?

Q. What is this document?

A. As I understand it, this is a document where he is writing essentially a position statement where I believe he is the sole author, and he is giving his overview of his reading of the literature in this gender-affirming surgery and his conclusions from that and recommendation.

Q. Do you understand this document to be providing an opinion on whether or not gender-affirming surgery is necessary

for the treatment of gender dysphoria, medically necessary?

A. I'm sorry, opinion? Could you ask that again, please.

Q. Do you understand this document to be providing what I'll say an ultimate conclusion on the medical necessity of gender-affirming surgery for the treatment of gender dysphoria?

A. No. My interpretation this is purely clinical guidance both for custody staff and for health care staff who probably know very little other than the training that they get. So it's kind of a primer or an overview to help them think through these issues. That's my interpretation on this. But I wouldn't call it all -- I don't believe this was like his testimony or something for court.

Q. Right. No. So all I said was reaching an ultimate conclusion. So do you understand this document to be reaching an ultimate conclusion that gender-affirming surgery is not medically necessary for the treatment of gender dysphoria?

MR. RODRIGUEZ: Asked and answered.

MS. MAFFETORE: No court context.

MR. RODRIGUEZ: Same objection. You can answer.

THE WITNESS: Well, when you say reaching a conclusion, we don't really use that term in medicine. My interpretation of this is this is Dr. Campbell's clinical guidance to health staff and custody staff in the North Carolina prison system.

BY MS. MAFFETORE:

Q. Understood. If you'll turn with me to page two of this document, Exhibit-8. If you'll look at the second little paragraph there under summary position statement. It reads after extensive and objective review and analysis of hundreds of studies and publications, it has been determined that gender reassignment surgery (GRS), as a treatment for gender dysphoria, is not medically necessary.

Did I read that correctly?

A. Yes.

Q. Great. Now I'd like to ask you if you agree with various aspects of Dr. Campbell's position statement. Could you turn with me first to page six.

A. (Witness complies.)

Q. Okay. So at the top of page six under the bullet there, the first main paragraph under that first bullet. If a procedure (surgery in this case) were the standard of care, there would be a single, or at most a discrete subset of procedures which have been determined by the medical community to be the most appropriate to treat the condition.

Did I read that correctly?

A. Yes.

Q. Do you agree with Dr. Campbell when he says in his position statement that if a procedure were the standard of care, there would be a single, or at most a discrete subset of

procedures which have been determined by the medical community to be the most appropriate to treat the condition?

A. So again, the issue I have with the standard of care, that that's a legal concept or term. The only issue I would have, I would probably say clinically indicated or when clinically indicated. By putting standard of care in quotation marks, that's kind of putting a legal spin on this.

Q. Okay. So if we -- if it said -- is your only issue with this statement here the fact that it uses the term standard of care rather than clinically indicated or some other term of that nature?

A. Well, the question I have -- I'm not sure which surgery Dr. Campbell is referring to because I know -- I'm aware that there's a lot of different types of surgery that are called gender-affirming surgery. So I'm not sure which specific one he's referring to in this paragraph.

Q. Under. Are there other conditions other than gender dysphoria for which there are a variety of medical options for treatment depending on the severity of the condition?

A. Yes.

Q. Which ones?

A. Well, I would say -- for example, I can speak immediately to depression, clinical depression, that you could treat with counseling, psychotherapy, there's different types of psychotherapy you could treat with. You could treat with

medications, antidepressants. There's three, four, five different classifications of antidepressant medications. Some patients with severe depression might need electroconvulsive therapy, ECT. Some patients might need an antipsychotic. Some night need hospitalization. Some patients that are not taking care of themselves and pose imminent risk to themselves or others might need civil commitment or hospitalization against their will or a guardianship. So yes, I think there's a lot of different options to a pretty straightforward thing like depression.

Q. So do you agree with Dr. Campbell when he says in his position statement on page six that the overwhelming expectation would be that excluding patients who decline surgery against medical advice?

A. I'm so sorry, where are you, please?

Q. I'm at the third bullet point now.

A. Thank you.

Q. The overwhelming expectation would be that excluding patients who decline surgery against medical advice, that virtually every patient with this condition and without contraindications would need to be provided the procedure in order for it to be considered medically necessary.

A. So what I would say, in medicine, it depends. There would always be -- there's no always or everyone. There's always an exception. So I slightly disagree with Dr. Campbell

here in that there can be alternatives to surgery. For example, psychotherapy or individual or group therapy. There's a lot of different things that could be considered prior to or in addition to advancing treatment before going to surgery.

Q. You just spoke previously about some of the different ways that depression is treated based on severity, and one of the things, you know, was electroconvulsive therapy, correct?

A. Yes.

Q. In your opinion is it sometimes medically necessary for individuals with depression to receive electroconvulsive therapy to treat their depression?

A. Yes.

Q. In your experience, what percentage of individuals with depression go on to require electroconvulsive therapy in order to treat the depression?

A. I don't know the number off the top of my head. I would say it depends on population you're talking about. If you're talking about like geriatric patients that are in nursing homes or if you're talking about medically compromised individuals. You would have to clarify what patient population you're speaking of. I wouldn't be able to give you a ballpark number.

Q. In any of those patient populations, would you say that the ballpark number is higher than 25 percent?

A. I would say it's probably rare. It's not common

unless if the patient has a history of chronic treatment-resistant or treatment-refractory depression that has not responded to multiple past medication trials and individual therapy and other therapies. Only like protracted treatment resistant then, yes, ECT would probably be used.

Q. So in any patient population would that be more than 25 percent of the cases?

MR. RODRIGUEZ: Asked and answered. You can answer.

THE WITNESS: I think I said it's pretty rare. It's not a common, except if perhaps if you're talking about a hospitalized patient population. Again, it would be a hypothetical, but I don't think it would exceed 25 percent.

BY MS. MAFFETORE:

Q. Is the fact that fewer than 25 percent of individuals with depression ever require electroconvulsive therapy make it any less medically necessary for those who do require electroconvulsive therapy for the treatment of their depression?

MR. RODRIGUEZ: Object to the form. You can answer.

THE WITNESS: So there's lots of different variables to consider with electroshock therapy or electroconvulsive therapy. I use the word shock. Unfortunately that's still pejorative. People think One Flew

Over the Cuckoo's Nest. So it's very negative and a lot of family members and advocacy groups are very anti-ECT. So a lot of it has to do with informed consent, getting the patient or their family member to consent. So I would say ECT is very complicated and it's -- there's no always or -- I would say it's particularly complicated because of the stigma and societal issues also.

MS. MAFFETORE: Understood.

THE WITNESS: Sorry. And also because in some locations you may not have psychiatrists. There's a national shortage of psychiatrists and you may not have a psychiatrist who knows and is competent to do ECT and a hospital or anesthesia service. So it's complicated. You have to have additional layers, which makes it more complicated.

BY MS. MAFFETORE:

Q. Sure. Are there any other conditions of which you're aware where a certain procedure or treatment is only necessary for an individual if their condition reaches a certain level of severity?

MR. RODRIGUEZ: Object to the form. You can answer.

THE WITNESS: Well, again, I'm not a surgeon. So I would say if someone has an appendicitis, they are -- that's an emergency and they need surgery and it's not something you would wait until, you know, they rupture or --

because we know from experience that if you don't do something that they're going to have a bad outcome. They could potentially if they get septic. So --

BY MS. MAFFETORE:

Q. I think that was actually the inverse of the question that I asked. What I asked is are there other conditions -- we were just discussing depression and electroconvulsive therapy being an option for individuals with particularly severe depression. But I was asking are there other conditions for which surgery only becomes necessary for an individual or a procedure only becomes necessary for an individual if their condition reaches a certain level of severity?

MR. RODRIGUEZ: Objection to form. You can answer.

THE WITNESS: What I would say -- again, the caveat is I'm not a surgeon, but with some back conditions the orthopedic surgeon might encourage the person to get physical therapy, to do physical therapy. And then only if the physical therapy is not improved or it doesn't resolve or improve the condition or there's additional nerve damage or nerve impingement then surgery would be -- it has to occur. Otherwise there will be continued pain suffering and disfigurement.

BY MS. MAFFETORE:

Q. Understood. So turning backwards to page four of Dr.

Campbell's position statement. I'm looking at the second to last paragraph. Dr. Campbell states here that this phenomenon of de-transition is critically important in considering treatment options for patients, particularly when treatment involves either irreversible or incredibly difficult/poor outcomes, such as surgeries.

Did I read that correctly?

A. Yes.

Q. Do you agree with Dr. Campbell when he said in his position statement that de-transition is critically important in considering treatment options for patients, particularly when treatment involves either irreversible or incredibly poor outcomes, such as surgeries?

A. So I wasn't asked to look at this issue, de-transitioning, and I don't have an opinion on this issue.

Q. What is your understanding of how common de-transition is among transgender adults?

A. Again, I was not asked to give an opinion or to look in that, so I don't have an opinion on that.

Q. So to the extent that this discussion factors into Dr. Campbell's articulation of medical necessity, you have no opinion one way or the other as to this particular aspect of that definition?

MR. RODRIGUEZ: Object to form and speculation. You can answer.

THE WITNESS: Again, like I testified earlier, I was not asked by Mr. Rodriguez or the legal team here to look at that. But if this is an issue of concern or they want me to, I would gladly do a literature review, look at the literature, look at -- maybe even request or recommend that Dr. Li look at that literature because she's really the expert in the comparative research literature. But no, as we sit here today I was not asked to look at that and I'm not prepared to give an opinion about that.

Q. But you did testify that you reviewed Dr. Campbell's position statement in preparation of your expert report, correct?

A. Yes.

Q. And you reviewed -- or your report states that you reviewed the literature that Dr. Campbell relied upon, correct?

A. I don't recall reading the article about de-transition or the Psychology Today De-Transition. So some of these articles I did not read and I -- I have read the Gibson Collier ruling. Some of these are not medical articles. They're like -- like more lay press. Like Psychology Today is not a peer-reviewed. So what I would say is I generally agree with Dr. Campbell and this position statement. But I would need to do a deeper dive to be able to answer any questions from a reasonable -- to be a better expert on de-transitioning.

Q. Understood. So sitting here today, you can't testify

to how common de-transition is among transgender individuals who have had gender-affirming surgery?

A. That's fair.

Q. And you can't testify to how common de-transition is among transgender individuals who have been on hormone therapy for 10 years or more?

A. That's fair.

Q. Okay. So turning to page nine. At the top of page nine, Dr. Campbell writes treatment recommendations are developed through evidence-based medicine/practice and are modified based on findings from continuous future studies.

Did I read that correctly?

A. Yes.

Q. He then goes on to note -- it is the third sentence of the first real paragraph -- the entity most often referred to for guidance regarding treatment of gender dysphoria, namely WPATH (World Professional Association for Transgender Health), simply does not utilize these criteria in developing their standards of care.

Did I read that correctly?

A. Yes.

Q. Do you agree with Dr. Campbell when he says in his position statement that treatment recommendations should be developed through evidence-based medicine and practice and are modified based on findings from continued future studies, but

that WPATH simply does not utilize these criteria in developing their standard of care?

MR. RODRIGUEZ: Object to the form. You can answer.

THE WITNESS: So I generally agree with some of that. But I would say that my opinion was strengthened when I read Dr. Li's report and her actual -- because she's actually a trained -- she has a Ph.D. in comparative effectiveness of studies. And no disrespect to Dr. Campbell, but I don't believe he has that. So Dr. Campbell is more of a clinician and health care leader, but Dr. Li has devoted her career to statistical analysis. So based on Dr. Li's report and her literature review I do agree with that.

BY MS. MAFFETORE:

Q. So your testimony today is that based on your review of Dr. Li's report, you agree that WPATH does not utilize evidence-based medicine or practices in developing their standards of care?

A. No, that's not what I testified to. What I said is they over -- in my opinion, in my professional opinion, at times WPATH over generalizes or overstates the existing literature and they don't provide -- most practice parameters that I have been involved in and published or been aware of practice guidelines or practice parameters, they will list what is the evidence to support this. Is it tremendous, moderate,

mild? Like what's the level of data to support this? In my opinion, WPATH doesn't provide that, that data specifically with regard to gender-affirming surgery.

Q. Okay.

A. Sorry. And the long-term outcomes related to gender-affirming surgery.

Q. So my question is, do you agree with Dr. Campbell when he says in his position statement that WPATH does not utilize evidence-based medicine practices in developing their standards of care?

MR. RODRIGUEZ: Object to the form. Mischaracterization of the text of the exhibit. You can answer.

THE WITNESS: So what I understand is WPATH is a group of -- it's a membership organization and the people that write these -- that wrote the most recent SOC don't kind of check what they do or their potential conflicts at the door. And if you're going to write any kind of an article for a scientific publication you have to disclose if you're an investor or you own stock, you have been funded by drug company money or what have you. If you have a copyright or you have a patent to a procedure or equipment. And same thing -- so my opinion is that WPATH, they may have some evidence-based literature in their studies, but they don't disclose inconsistencies or the degree of variability in the studies

that they cite.

BY MS. MAFFETORE:

Q. Okay. So turning to page 10 then. The last sentence of the first paragraph there. Dr. Campbell states, in fact, it is argued by many that WPATH is activist-led rather than evidence-led. Did I read that correctly?

A. Yes.

Q. Do you agree with Dr. Campbell's assertion in the position statement that WPATH is activist-led rather than evidence-led?

A. I don't have an opinion.

Q. Did you consider Dr. Meyer to be an activist?

A. So I consider Dr. Meyer to be an advocate for his patients, which I think is noble and forth while and worthy. In his effort to try to help people that have gender dysphoria is noble. But I'm not prepared, as we sit here today, to say whether I think Dr. Meyer is an activist or a non-activist because I don't -- I don't understand how you're defining activist.

Q. So I'm not defining activist. I'm asking you if you agree with the statements that Dr. Campbell has made, to be clear. During your time working with Dr. Meyer, did you feel that he was not lead by evidence?

A. No. I think that the thing that I learned the most from Dr. Meyer, he appreciated and taught me that gender

dysphoria is a spectrum, transgendered individuals a spectrum. And not every one that is transgendered or gender dysphoria necessarily wants hormones or needs hormones. And vice versa, not everyone that has been on hormones wants or needs surgery. That some people are perfectly -- do very well and he's followed patients from childhood to adulthood. So I really sense that Dr. Meyer, he gets it, he has the whole picture. And to the best of my knowledge Dr. Meyer has not been doing a lot of litigation work. So yes, I do respect what Dr. Meyer has to say and his opinions.

Q. Did you feel that he was lead by evidence?

A. Yes.

Q. Lower down on -- actually the next sentence on page 10 Dr. Campbell notes conflicts of interest among the organization are also of significant concern.

You touched on this a little bit a moment ago, but do you agree with Dr. Campbell's assertion that conflicts of interest among WPATH are of significant concern?

A. I would say yes. If they haven't disclosed -- every time I give a presentation I have to disclose all my conflicts. Every time I write a book or book chapter or article I have to disclose all of that. So yes, I would say if it's not listed in their SOC, that's a problem.

Q. Do you know whether their conflicts of interests are listed in their SOC?

A. I haven't looked at it recently, but I think that that should be -- that should be an important thing for the reader to have any potential issues of objectivity or conflict of interest should be listed at the beginning of the article.

Q. Sitting here today, do you know whether or not that is included?

A. I haven't read the WPATH in a couple of weeks, so no.

Q. Do you agree that the Endocrine Society has significant conflicts of interest that should be of concern?

A. I would say it's possible because physicians often get grant support or research funding. So again, I would say yes, that that's -- they would need to disclose any potential conflicts in the article.

Q. Do you think that the American Medical Association has any conflicts of interest that are of concern?

A. Yes.

Q. What about the American Academy of Family Physicians?

A. It's possible they could.

Q. The American Academy of Pediatrics?

A. Yes.

Q. The American College of Obstetricians and Gynecologists?

A. Yes.

Q. The American Psychiatric Association?

A. Yes.

Q. The American Psychological Association?

A. Yes.

Q. The Pediatric Endocrine Society?

A. Yes.

Q. So are all of those medical organizations less reputable by virtue of the fact that they may or may not have conflicts of interest?

MR. RODRIGUEZ: Objection to form. Mischaracterization of testimony.

THE WITNESS: That's not what I'm testifying to. I'm basically saying -- I have given talks for psychologists and for pediatricians and family physicians and other groups, and every time I gave a talk if it's sponsored or under the auspices of those accrediting organizations I have to disclose if I own stock or if I'm going to present objective, neutral, non-biased information. So any time any kind of publication or lecture, grand rounds, I have to disclose, you know, if I own stock or if I own intellectual property or what have you. So yes, I think all of those professional groups, it's incumbent on them to do that when they have anything that they're putting out as endorsed by those groups.

BY MS. MAFFETORE:

Q. Sitting here today, do you have any reason to believe that WPATH has a conflict of interest that would somehow undermine the credibility of their standards of care?

MR. RODRIGUEZ: Asked and answered. You can answer.

THE WITNESS: So I testified to this earlier. It's unclear to me how many people in WPATH -- because we're a member organization -- have or stand to gain benefits -- similar to what Dr. Campbell wrote in his report, stand to gain referrals, patient referrals, or legal cases serving as experts or standing to gain or profit from this. And so the question is potential bias or potential conflict of interest.

BY MS. MAFFETORE:

Q. Okay. So looking down the second to last paragraph.

A. Sorry. On page --

Q. On the same page, page 10 where we were.

A. Thank you.

Q. This paragraph states this concern is supported by the fact that ECRI (Emergency Care Research Institute), the DHHS-appointed Agency for Healthcare Research and Quality (AHRQ) for the National Guideline Clearinghouse (NGC), has failed to provided Trust Ratings for either WPATH or the Endocrine Society guideline for the treatment of gender dysphoria. The reason for this lack of inclusion was because only a few of the recommendations were supported by the systematic review; the majority were not, and that the agencies did not use a systematic review process in developing their guidelines.

Do you agree with Dr. Campbell that WPATH and the Endocrine Society did not use a systematic review process in developing their guidelines in the treatment of gender dysphoria?

A. I don't have an opinion. I'm not familiar with any of those. I mean, I'm generally familiar with one of them, but I need to read the documents to form my own opinions. I don't have an opinion today as we sit here.

Q. I understand. Looking back at page two, the sentence that we referenced previously. Do you agree with Dr. Campbell's ultimate assertion that as a general principle, gender reassignment surgery (GRS) as a treatment for gender dysphoria is not medically necessary?

MR. RODRIGUEZ: Object to this characterization of the text of the document. You can answer.

THE WITNESS: So I would respectfully disagree. I think that there may be a condition or a situation or a patient case where gender-affirming surgery, formally known as sexual reassignment surgery, might be medically necessary.

BY MS. MAFFETORE:

Q. Understood. If you look with me at page 11. The last paragraph of the report.

A. (Witness complies.)

Q. Dr. Campbell states accordingly, to support these procedures given all these concerns would be in conflict with

the most critical imperative in medicine, primum non nocere (First, do no harm). The imperative is the underpinning of the oath all physicians take. In order to ensure the most appropriate, effective, and safest care to patients, clinicians must exercise due diligence in evaluating all available information in formulating recommendations to patients. The evidence regarding GCS does not provide sufficient confidence that the procedures should be undertaken without concern for having violated that oath.

Did I read that correctly?

A. Yes.

Q. Do you agree with Dr. Campbell that the provision of gender-affirming surgery based on the evidence available would violate the oath First, do no harm?

MR. RODRIGUEZ: I'm going to object to the form and mischaracterization of the text. You can answer.

THE WITNESS: Right. Dr. Campbell writes gender-confirming surgery and I think you asked me about gender-affirming surgery, and I'm not clear which one specifically you're referring to. Because I have opinions -- I potentially have opinion depending on which kind of surgery you're talking about.

BY MS. MAFFETORE:

Q. Throughout this document is it the case that Dr. Campbell uses GRS and GCS interchangeably with no definition to

differentiating either?

A. On page two of the report I read gender reassignment surgery, parens, GRS, close parens.

Q. Does he provide a definition for that?

A. I don't see a definition provided.

Q. Do you believe that doctors who provide gender reassignment surgery would violate medical ethics by doing so?

A. No.

Q. Do you believe that doctors who provide gender confirmation surgery are violating medical ethics by doing so?

A. Please, how are you defining gender confirming surgery?

Q. I am not. I am merely referring to the words that are -- the acronyms that are used by Dr. Campbell in the document that they are referencing.

MR. RODRIGUEZ: I'm going to object to the characterization of the text embedded in that question.

THE WITNESS: Without knowing what GCS -- what he's referring to and what specific inclusion or exclusion criteria and type of surgery, I don't have an opinion.

BY MS. MAFFETORE:

Q. As you understand the term gender-affirming surgery, do you believe that doctors who provide gender-affirming surgery are violating their medical ethics by doing so?

MR. RODRIGUEZ: Asked and answered. You can

answer.

THE WITNESS: I would say it would depend on if they've done a true risk, benefits -- risk, benefit analysis with the patient and truly provided similar to what Dr. -- I'm so sorry. I'm blanking on his name, the surgeon in this case. The urology surgeon, Dr. -- it will come to me. But he listed a bunch of medical complications and risks. So I think it's incumbent upon the surgeon and/or the anesthesiologist to review all of those risks, benefits, and alternatives. And I do agree with Dr. Boyd that it's not just the surgery, but it's the patient's perception of what the surgery will or won't do for them because if they have had trauma, abuse, neglect or PTSD, no amount of surgery is going to fix that, as in this case. So I would say it all depends on the patient and the comorbidities. But provided that the surgeon, the anesthesiologist or the other individuals involved, provided they truly get informed consent from the patient with that risk, benefit, alternatives analyses, then in my opinion they would not be violating their medical oath and duty to the patient.

BY MS. MAFFETORE:

Q. Great. Thank you. Going back to your report, Exhibit-1, on page 20. You note at the bottom of page 20 under the heading three, Dr. Ettner's formulation of medical necessity, that Dr. Ettner and WPATH refer to the AMA's

definition of medical necessity, correct?

A. Correct.

Q. Do you know whether the AMA endorses the WPATH standards?

A. When you say endorse, could you clarify what you mean by endorse so I can answer your question?

Q. They have stated an endorsement of the WPATH standards.

A. So to answer your question I would say the AMA House of Delegates, which is a bunch of individuals that self-identify and seek to be placed into this house of delegates, that in the reference committee they've referred to WPATH, but it's not clear to me that the American Medical Association as a group has essentially given full endorsement to the WPATH SOC 7 or SOC 8 to date.

Q. So your testimony is that it's not clear to you whether the AMA has endorsed the WPATH standards?

A. That's correct.

Q. Are you aware of any other -- of whether any other medical societies of which you are a member have endorsed the WPATH's standards?

A. Again, going back to the issue of endorse, I think several groups, the American Psychiatric Association, NCCHC, other organizations reference WPATH, but that doesn't mean -- in my interpretation that doesn't mean they endorse everything.

And if provided with the literature review that Dr. Li performed that, in my professional opinion, could likely change many opinions of individuals if that were to come to light.

Q. You further note at the bottom of page 21, moving onto page 22, that the definition of medical necessity referred to from the AMA is maintained in the medical review category and concerns physician reimbursement issues, correct?

A. So that's where medical necessity is most commonly promulgated would be AMA. That's fair.

Q. You state that it is maintained in the medical review category and concerns physician reimbursement issues?

A. I'm sorry, I didn't understand the question.

Q. Is that what your report states, that it is maintained -- that the definition of medical necessity is maintained in the medical review category and concerns physician reimbursement issues?

A. So as I have stated in my report here, specifically on page 21, the AMA is the art and science of medicine and their mission statement has to do with public health. And doctors have complained to the AMA for many years that insurance companies are denying care or not approving or funding care. So the AMA took on -- has taken on insurance companies and other commercial insurance groups. And so the AMA came up with this definition more reactive based on insurance companies denial of health care services.

Q. I understand. So regarding the resolution, you state that the express intention of the resolution is to articulate a basis for obtaining insurance coverage or reimbursement for certain types of care.

Did I read that correctly on page 22, the bottom of the first full paragraph?

A. Yes.

Q. You then go on to state, these coverage and reimbursement issues are not applicable within jails and prisons and other correctional settings.

Did I read that correctly?

A. That's correct.

Q. Why would the AMA be focused on removing financial barriers for this particular type of care?

MR. RODRIGUEZ: Objection, speculation. You can answer.

THE WITNESS: My sense is that the AMA is all about removing financial barriers for all care, whether you're transgender or not transgender. And that's again admirable. They are trying to make it easier for patients to get the health care that they need. So again, they're trying to remove these insurance or financial barriers. So that's my interpretation of why the AMA wrote this.

BY MS. MAFFETORE:

Q. Is that because the care is medically necessary

regardless of the financial implications in certain circumstances?

MR. RODRIGUEZ: Objection to form. You can answer.

THE WITNESS: No. I would say again, the AMA doesn't opine on medical necessity. That's up to the individual physician based on an evaluation, a review of records, and actually seeing the patient and again, weighing the risk, benefits, and analysis and alternatives with the patient.

BY MS. MAFFETORE:

Q. Right. But in the context where a physician has decided that care is medically necessary, the AMA is seeking to remove financial barriers that would inhibit access to that care?

MR. RODRIGUEZ: Objection to form and speculation. You can answer.

THE WITNESS: They're trying to do that in the community where there's third-party payment. In a jail or a prison there's not third-party payment so it's not -- you're comparing apples and oranges. They're totally different funding streams and health care is funded a whole different way. It's funded by state or county tax dollars or tax revenue.

BY MS. MAFFETORE:

Q. Right. But in a prison setting isn't the prison responsible for providing access to care that would typically be afforded through insurance coverage?

A. No.

Q. No? Okay. So on page 24 of your report --

A. Sorry, could I clarify my response? I couldn't answer that a yes/no. The no -- it has nothing to do with insurance reimbursement or what insurance -- it has to do with what is a constitutional level of care, is the health care medically necessary. And we have a constitutional duty to provide access to care and continuity of care as determined by medical need, irrespective of insurance reimbursement.

Q. Right. And so my question was in a prison setting isn't the prison responsible for providing access to care that would typically be afforded through insurance coverage?

MR. RODRIGUEZ: Objection to form. You can answer.

THE WITNESS: No. Because we do a lot of things in prisons that commercial insurance wouldn't do. We actually provide probably more care to inmates that commercial insurance companies would never pay for. Mental health, I can speak to that directly. We do a lot of things that if we try to bill insurance companies they would not be reimbursed, but they're still services that we provide.

BY MS. MAFFETORE:

Q. Are there any services provided that would be covered by insurance companies that the carceral setting does not provide?

A. I don't have enough knowledge of all the different medical or surgical procedures that our system does or the North Carolina system does. So without that data, I wouldn't be able to answer your question.

Q. Okay. Now I'd like to move on to page 24 of your report. Looking to note six at the bottom. You state that the studies referenced by Dr. Ettner are low-quality studies and that there is a lack of high-quality long-term research demonstrating the efficacy of gender-affirming surgery in treating gender dysphoria in the United States, is that correct?

A. That's what I wrote in my report.

Q. What do you mean by low quality?

A. So I testified earlier what you really want is kind of gold standard research that's double-blind, placebo-controlled or multi-center randomized clinical trials. Some sort of a control group, having baseline measures, using validated baseline measures, using validated outcome measures. There has to be some sort of empirical research and good statistical methodology and unfortunately to date -- and hopefully they do more -- but the studies that have been done are -- they lack all of the above.

Q. Are you aware of whether there are any other widely-accepted treatments that are supported by only low-quality evidence?

A. Probably, yes.

Q. Do you know what any of those are?

A. I don't -- as we sit here today, off the top of my head, I can't think of any immediately that come to mind. But I can say that in child psychiatry we don't have as much literature or data as we do in adult psychiatry, so a lot of times medications are used off label, but they're based on some type of study that's been done in adults. So that would be an example of -- you still have to have some consensus by professionals in the field and there's a larger organization and there's board certification, so there's some quality measures in place. And then obviously there's the medical board that reviews issues of practitioners that fall below the standard of care. But I would say child psychiatry is probably the best example that immediately comes to mind compared to adult psychiatry where there's much less research studies compared to the adult population.

Q. Why are there fewer research studies in the context of children or adolescents?

A. It's multifactorial. One, there's less child psychiatrists -- there's a national shortage of adult psychiatrists. There's even less child psychiatrists. There's

less child psychiatrists that want to do research. Doing research with psych meds in children and adolescents is seen as kind of controversial. So there's a variety of reasons why getting consent from a youth, a minor is an issue. You have to convince the parent or legal guardian. There's a lot of media coverage of like the risk of psych meds and the damages they can do to kids. So those are some of the reasons why it's really hard to do randomized, double-blind, placebo-controlled studies in kids and adolescents.

Q. But nonetheless, treatment is provided to those populations you stated based on studies done with adult populations? Is that --

A. There's actually clinical practice guidelines. The American Academy of Child and Adolescent Psychiatry which is a U.S.-based organization. They write or disseminate practice guidelines. There's physician statements. There's literature reviews of management or treatment of depression or ADHD or -- pick your condition. So that's the difference is that there is some clinical guidance given to the field and always under the caveat of do no harm and be careful. So I would say child psychiatrists, those are the overarching safety is having clinical guidelines and practice parameters both by the American Academy of Child and Adolescent Psychiatry, and then their journal and then their CME programs and that's how they kind of make sure that things are safe. But still medicines

can be called black box and get black box warnings in spite of all of the above.

Q. So you also note in the same footnote that there is no published literature demonstrating the efficacy of gender-affirming surgery in treating gender dysphoria in incarcerated individuals.

Did I read that correctly?

A. Yes.

Q. Are you aware of whether the North Carolina Department of Adult Corrections has adopted a community standard for the provision of health care to its prisoners?

MR. RODRIGUEZ: Object to form and speculation. You can answer.

THE WITNESS: I'm not sure what the community standard -- how you're defining that.

BY MS. MAFFETORE:

Q. Are you aware of whether any policy by the North Carolina Department of Adult Corrections, previously the North Carolina Department of Public Safety, states that they apply community standards in the provision of health care to incarcerated people within their system?

A. I'm not aware of that. I would be very -- I would need to see that document to respond to your question because just because something is done in the community doesn't mean that it's standard of care. And corrections have to be very

careful because there are inherently coercive settings. So we have to be even more careful in corrections because we don't want to hurt anyone or harm anyone.

Q. So as you sit here today, you're not aware of whether or not the North Carolina Department of Public Safety, the North Carolina Department of Adult Corrections have adopted community standards in any of their policies?

A. I would have to review that -- I don't recall -- I reviewed a lot of documents, but I don't recall referring to that.

Q. Understood. Does a treatment method need to be studied specifically within the carceral setting before you accept it as medically necessary for treatment of a condition in that setting, even if it has been studied to be advantageous outside of that setting?

A. I would say there needs to be at least some research to provide guidance in the field because corrections is very different from the free world.

Q. For all of the various conditions and treatments that you provide in your role as director of mental health services at UTMB, have all of those conditions and treatments for all of those conditions been studied in the carceral setting as well as in the community setting?

A. As I understand it, yes, they're done -- the hormone treatment -- gender-affirming hormone treatment is done in the

community and yes, we provide pretty much the same thing in our setting.

Q. Understood. Have there been studies specifically as to the carceral setting is my question for each thing that you provide?

A. Dr. Meyer and I had discussed looking at that because we have one of the largest state -- no. We are the largest prison state system in the country. I think we have looked at -- because we have a robust quality review process, we have looked for adverse outcomes and to date we have not had any. So we rely on our clinical practice in addition -- even though we're not doing research, we look for any side effects or patient complications to help guide us.

Q. So why would it make a difference then whether there have been -- there has been published literature demonstrating efficacy of gender-affirming surgery specifically within the carceral setting?

A. Because the intervention is permanent. It's largely irreversible. And individuals that are incarcerated, like I testified to earlier, they're thinking the here and now. They're not necessarily thinking long term and they're prone to talk to their cellmate or others and get bad advice and make impulsive decisions. So they really need to think about the long-term picture. So that's why there needs to be additional safeguards in place, in my opinion.

Q. Have you ever approved the provision of medical care to an incarcerated prisoner where there is not high-quality, long-term research demonstrating it's efficacy in U.S. prison settings?

MR. RODRIGUEZ: Object to the form. You can answer.

THE WITNESS: No.

BY MS. MAFFETORE:

Q. Have you ever approved the provision of medical care to an incarcerated prisoner where there is not high-quality, long-term research demonstrating its efficacy in a carceral setting?

MR. RODRIGUEZ: Objection to form.

THE WITNESS: Yes.

BY MS. MAFFETORE:

Q. When?

A. We have had a handful of patients that had severe self-harm, head banging, cutting, self-injuring, inserting items, and I have approved the use of a medication -- an opiate type of medication blocker for those patients. And the literature -- and that is extremely limited and there's no literature at all in correctional settings -- and I have approved that medication non-formulary for both juveniles and for adults in our systems.

Q. Why did you consider it appropriate to do so absent

that literature?

A. Because I personally reviewed the literature. I reached out to colleagues in the field and discussed the risks, benefits and alternatives. I also spoke to our pharmacy leadership and our psychiatric pharmacist and got -- similar to the North Carolina case, multidisciplinary approach, talked to nursing staff and talked to custody staff. And so all of that together, the opinion was that the potential benefit of the medicine outweighed the potential risks. And so we did utilize that medication in those circumstances.

Q. So you concluded that that degree of literature was not necessary for you to appropriately utilize that medication for those patients in that circumstance?

A. So not necessarily -- there is literature, but the literature is in a different type of patient population. It's not an incarcerated population. It's individuals in the free world with intellectual impairments, formerly known as mental retardation, and folks with autism and autistic spectrum disorders. And also there's separate literature on people with borderline personality disorder that cut or self-harm. So I looked at both set of literature to help guide the use of that medication in a carceral setting.

Q. Understood. On page 26 of your report you note in the first full paragraph under the formulation of the phrase medically necessary as used by Dr. Ettner and WPATH, an

intervention which may provide some benefit vis- -vis a patient's gender dysphoria becomes medically necessary. The implication of such a formulation goes beyond interventions to treat gender dysphoria. The same logic make a host of other interventions medically necessary to treat other conditions. For example, a patient with a perception of a large or crooked nose, small breasts, skin wrinkles, droopy eyelids, acne scars/scarring, a large mole, or facial sagging or other distress or discomfort due to perceived facial or body features may derive a benefit from procedures targeting that body feature. I'm going to skip to the next sentence. Similarly, someone who experiences distress or discomfort from a mole, skin tag, birthmark, scar or tattoo, may derive a benefit from a dermatological procedure such as mole, skin tag, birthmark, scar or tattoo removal utilizing laser treatments or the latest surgical technology or procedure. Under Dr. Ettner's logic these procedures would be medically necessary because they may well benefit the patient by alleviating, to some degree, their perceived distress from their physical appearance or characteristics or otherwise improving their lives.

Did I read that correctly?

A. Well, other than those parts that you didn't say, yes, that's generally true.

Q. In your opinion are droopy eyelids a serious medical condition?

A. I would say it would depend. It could be a sign of someone having myoasthenia gravis. It could be a sign of multiple sclerosis. It could be a sign of a lot of different autoimmune. So it would depend.

Q. Is that the situation that you're discussing in this paragraph is a situation where somebody has droopy eyelids as a consequence of one of those other impairments?

A. It's possible.

Q. Are skin tags a serious medical condition akin to gender dysphoria on their own?

A. It would depend.

Q. On their own?

A. I'm sorry. I was saying it would depend on the amount and severity and where the skin tags are and if people stare at that individual or if that individual feels like people stare at them. So I would say it would really depend, the context.

Q. Okay. So in your opinion, do droopy eyelids or skin tags cause the same degree of distress on their own without any underlying condition as gender dysphoria?

MR. RODRIGUEZ: Objection to form, speculation. You can answer.

THE WITNESS: So I would say it would really depend on the individual and what other comorbid issues are going on in their life. If they have any comorbid medical or mental health conditions, if there's trauma, abuse or neglect.

If they're incarcerated or not. So there's a lot of additional stressors. I can't just compare a mole to gender dysphoria. You really have to have the context to be able to assign weight to distress or impairment.

BY MS. MAFFETORE:

Q. Is there a clinical diagnosis for the distress someone experiences related to droopy eyelids?

A. It's possible. There's a condition called body dysmorphic disorder, which I used to work with and treat individuals. Yes, individuals could truly have a real body feature but then they magnify it a hundred or a thousandfold and they are quite impaired by that. So yes, you can have significant impairment from either a real body feature or a perceived body feature that's distressing.

Q. What about is there clinical diagnosis for the distress someone experiences related to skin tags?

A. There could be. It could be an adjustment disorder. Could be major depression. Someone could become suicidal. Yes. So there's a variety of sequelae that could happen from someone who has one or multiple distressing skin tags or other dermatologic conditions.

Q. I guess I'm not a hundred percent understanding your critique of Dr. Ettner here. So based on the conditions that you just described then, would you consider it medically necessary to provide surgery to treat those conditions under --

those conditions of severity that you just explained?

MR. RODRIGUEZ: Object to the form as mischaracterization of the text.

THE WITNESS: First of all, Dr. Ettner in my opinion is not -- she's not qualified to opine on medical necessity because she's not a physician. She's a psychologist. So it just seems like she's throwing out all these terms but it's -- I would need more of the actual -- similar to what North Carolina does in their policies and procedures and practices, they look at the patient, they look at all of the history, the custody issues, the mental health issues, they look at comorbidities, they look at their adjustment, how they're progressing, how they're doing in their carceral setting. And that's what Dr. Ettner lacks. She doesn't consider any of the other -- she just says automatically gender dysphoria, medical necessity, and that's not how the real world works for physicians that deal with this sort of stuff through our training and on a day-to-day basis.

Q. I understand.

MR. RODRIGUEZ: Do you want to take a break?

MS. MAFFETORE: I was going to say, this is a natural break in my outline.

- - -

(A break was taken, 3:13 p.m. - 3:28 p.m.)

- - -

BY MS. MAFFETORE:

Q. Dr. Penn, after that brief break, just another reminder that you are still under oath. I want to pick up at page 29 of your report. In the second paragraph under the heading The Risk-Benefit Analysis in Plaintiff's Case. You concluded that there was little to no clinical indications that plaintiff was or would be at risk of some severe distress, harm or disability absent the vulvoplasty.

Did I read that correctly? Second paragraph under the heading of The Risk-Benefit Analysis in Plaintiff's Case. Second paragraph under that heading.

A. Oh, yes. Thank you. Yes, that's correct.

Q. What do you mean by severe distress?

A. Well, that's what I was testifying to earlier when you were asking about like skin tags and all those different things. It's not just the finding of a physical abnormality or genitalia that one doesn't want to have or experiences as ugly or hideous or what have you. It's more the severe distress as evidenced by psychosocial impairments across settings. So it's the emotional distress. To answer your question about severe distress would be impairments in their activities to function, ability to work. For example, Kanautica -- Mrs. Brown, sorry, she has gainful employment. She works in the commissary. She has maintained relationships with family and her husband. So she's not showing the objective distress where she is suicidal,

requiring suicide watch, requiring emergency psychotropic medications, requiring inpatient psychiatric hospitalization. She's clinically stable in a female prison setting.

Q. And is it your understanding that Mrs. Zayre-Brown is currently employed by the prison system?

A. I understood she was working in commissary. I'm sorry, canteen, or she had some job. She may have had the job changed when she moved. I understand she's moved to different facilities. But she was gainfully employed and was also taking college courses and some other courses, as I understand from the record and from her testimony in her deposition.

Q. Just to make sure that I understand your testimony, you believe that hallmarks of severe distress are suicidal ideation, suicide attempts, being placed on suicide watch, requiring emergency psychotropic medications, requiring emergency hospitalization?

A. Those would be the manifestations of severe distress. But the day-to-day would be things like problems with sleep, either sleeping too much or not sleeping enough, your interests, your former areas of interest are diminished, guilt or rumination over different things in your life, decreased energy, or in Ms. Brown's case, the possibility of too much energy. Concentration could be impaired. Her appetite could be too much or too low. Weight gain or weight loss. And again, preoccupation with distress and frustration and feeling

overwhelmed. And then lastly, suicidal thoughts, yes.

Q. Is severe distress a prerequisite, in your opinion, to receiving care to treat a serious medical condition in the carceral setting?

A. No.

Q. Later on page 29, A, the heading, you said Plaintiff's Medical Records Do Not Demonstrate Clinically Significant Mental Or Emotional Distress.

Did I read that correctly?

A. Yes.

Q. You then go on to write in the first sentence of that paragraph the hallmark of gender dysphoria is clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Did I read that correctly?

A. Yes.

Q. Do you contend Mrs. Zayre-Brown's gender dysphoria diagnosis?

A. No.

Q. If not, what do you mean by plaintiff does not demonstrate clinically significant mental or emotional distress?

A. According to my review of her deposition with Mr. Rodriguez, the evaluation with Dr. Boyd she presented as euthymic, euphoric, good eye contact, animated. She described

she was hopeful in future, oriented about wanting to work as a paralegal while she attended law school once she was released. All again suggesting that she's hopeful and future oriented. She doesn't have a diminished or shortened sense of the future. So I would say all of those are examples showing that her gender dysphoria currently is not impairing or causing distress at this time.

Q. But you stated that gender dysphoria in and of itself is clinically significant distress or impairment, correct?

A. Well, the DSM criteria -- and I know there's been controversy about the diagnosis, whether it should be in the DSM or ICD or what have you. But to make the criteria you have to have clinically-significant distress or impairment. Kanautica Brown, by my understanding from records, because I was not allowed to evaluate her and I would have very much liked to have had the opportunity to do so, at this time her -- she has gender dysphoria. It's kind of chronic and low grade, but she's not having current acute distress from her gender dysphoria to the best of my ability from what I have seen or read or visualized.

Q. Are you aware of whether Mrs. Zayre-Brown is experiencing clinically significant distress related to her genitalia?

A. She has reported that and she's done things in the past, such as allegedly or reportedly putting a rubber band

around her phallus in the condition that she was not getting what she wanted, a referral in a timely manner. She saw it being not timely. And she has made conditional statements of wanting to rub the skin off her phallus as a threat. But outside of those two incidents, there were two incidents, one -- I believe both of those where there was a question about K2 use or some other substance. But outside of those four incidents my record review does not reveal anything at least in the last year or two where she's presented as distressed, despondent, needing emergency mental health evaluation, psychiatric admission or transfer, emergency psychotropic medications, placement on a suicide watch or suicide precautions, or transfer to the medical clinic for self-harm or self-injurious behavior.

Q. Okay. And so you mentioned your review. And so on page 30 of your report, first full paragraph, the beginning you note based on my review of plaintiff's medical records, including her mental health visits, routine checkups, sick calls, endocrinology appointments, and other medical records, the typical indicators of significant mental distress or impairment of the activities of daily living are not present.

Did I read that correctly?

A. Yes.

MS. MAFFETORE: Now I'm now going to hand you what I will ask the court reporter to mark Exhibit-9.

- - -

(Document marked as Exhibit-9 for identification.)

- - -

BY MS. MAFFETORE:

Q. The court reporter has just handed you what's been marked as Exhibit-9, which is was a document produced in this case with the bates stamp DAC 1182.

Do you recognize this document?

A. Yes.

Q. And is this document a North Carolina Department of Public Safety Self-Injury Risk Assessment dated December 11, 2020?

A. Yes.

Q. And I will represent to you if you see where it says offender number and it says 0618705 that other witnesses in this case have identified that that is Mrs. Zayre-Brown's offender number. Fair?

A. So I do recognize that offender number and I have memorized that during review of these charts. Yes, that's fair.

Q. Is this one of the -- well, first, do you see under current self-injurious behaviors where it says Ms. Blank indicated she has thoughts of ripping the skin off my pee-pee?

A. Yes.

Q. Okay. And moving forward I will fill in those blanks which are a redaction of Mrs. Zayre-Brown's dead name with Mrs. Zayre-Brown, just for clarity sake. Is that all right with you?

A. Or the plaintiff is fine. Sure. Whatever is easier.

Q. Under current suicidal ideation it states Mrs. Zayre-Brown stated she wants to be given a medication that will put me to sleep and keep me asleep. When asked for clarification, she stated I don't want to die but I feel like it is the best thing for me.

Did I read that correctly?

A. Yes.

Q. Looking at the bottom of this page, the last paragraph states Mrs. Zayre-Brown has had an increase in symptoms of gender dysphoria since August. And it goes on to state after the double dash, one of her greatest current fears is that someone will find out she still has part of a penis so it is an extremely emotionally arousing issue for her. Since that time, Mrs. Zayre-Brown's symptoms of depression have increased, and she has had thoughts of ripping the skin off her penis and thinks she may be better off dead.

Did I read that correctly?

A. Yes.

Q. Did you review this medical record before concluding that Mrs. Zayre-Brown does not have significant mental distress

or impairment?

A. Yes.

Q. I'd now like to hand you what I would ask the court reporter to mark as Exhibit-10.

- - -

(Document marked as Exhibit-10 for identification.)

- - -

BY MS. MAFFETORE:

Q. The court reporter has handed you Exhibit-10 which is a document bates stamped DAC 728. I will represent to you that it is a North Carolina Department of Public Safety Mental Health Progress Note dated 4/28/2021 pertaining to Mrs. Zayre-Brown.

Do you recognize this document?

A. Yes.

Q. Under Progress Towards Goals -- do you see where I'm referring to?

A. Yes.

Q. It notes Mrs. Zayre-Brown expressed many concerns about not having her appointment with UNC-CH urology scheduled yet. She gave a number of examples of how this is increasing her dysphoria, and she decided to put a band on her penis until her appointment is scheduled. She said she has had the band on for a week and a half. She was cautioned about the effects of

impeding blood flow and risk of infection. As described above, the undersigned spoke with Ms. Catlett, and she was able to convey to Mrs. Zayre-Brown how Ms. Catlett has been on top of it and has worked hard to facilitate this appointment. Ms. Zayre-Brown then agreed to take the band off her penis. The rest of the session addressed her specific concerns about having part of a penis left and what defines a woman. She explained it does not bother her if she is called fat or ugly but stated if she is called a man there is no tool in the toolbox to manage that. She stated I can't live with this anymore, and said the situation was acute now and not chronic. She also stated she is not complete now and that I'm ready to be complete.

Did I read that correctly?

A. Yes.

Q. Did you review this medical record before concluding that Mrs. Zayre-Brown does not have significant mental distress and impairment?

A. Yes.

MS. MAFFETORE: I'm now going to hand you what I will ask the court reporter to mark as Exhibit-11.

- - -

(Document marked as Exhibit-11 for identification.)

- - -

BY MS. MAFFETORE:

Q. Exhibit-11 is a document that was produced in discovery bates marked DAC 695. I will represent it's the North Carolina Department of Public Safety Mental Health Progress Note dated September 16, 2021 pertaining to Mrs. Zayre-Brown.

Have you seen this document before?

A. Yes.

Q. Under Progress Towards Goals, the last two sentences note she admitted that she had briefly considered putting a rubber band around her phallus as a means of forcing surgical intervention. The writer explained that Ms. Brown would only undermine her chances for gender-affirming surgery if she was considered to be emotionally unstable for treatment. She acknowledged understanding.

Did I read that correctly?

A. Yes.

Q. Is this one of the documents that you reviewed before concluding that Ms. Zayre-Brown does not have significant mental stressor impairment?

A. Yes.

MS. MAFFETORE: I'm now going to hand the court reporter what will be marked as Exhibit-12.

- - -

(Document marked as Exhibit-12 for

identification.)

- - -

BY MS. MAFFETORE:

Q. Exhibit-12 is a document produced to us in discovery bates marked DAC 680. I will represent to you it is a North Carolina Department of Public Safety General Administrative Note dated November 2, 2021 regarding Mrs. Kanautica Zayre-Brown.

Do you recognize this document?

A. Yes.

Q. The document notes under comments, Offender Brown made a statement of self-harm during today's FTARC, indicating that if she did not receive an update about progress on the decision regarding DTARC determination re: requested surgery, she would mutilate her phallus, referred to in earlier documentation as taking matters into her own hands.

Did I read that correctly?

A. Yes.

Q. Did you review this medical record or this administrative note before concluding that Mrs. Zayre-Brown does not have significant mental distress or impairment?

A. Yes.

MS. MAFFETORE: I'm now going to hand you what I ask the court reporter to mark as Exhibit-13.

- - -

(Document marked as Exhibit-13 for identification.)

- - -

BY MS. MAFFETORE:

Q. Exhibit-13 is a document that was produced to us in discovery which is bates stamped DAC 666 on the first page. I will represent to you that it is a North Carolina Department of Public Safety Mental Health Progress Note, December 6, 2021, relating to Kanautica Zayre-Brown.

Do you recognize this document?

A. Yes.

Q. On page two of the document at the top. Document notes under the subheading Progress Towards Goals, which is at the bottom of the previous page, reduced feelings of dysphoria, measured by rating dysphoric feelings on a scale from zero to 10. Zero equals no dysphoria. 10 equals extreme dysphoria. By being five or below at least three days a week. Today Offender Brown reported a Level of 11, it's high.

Did I read that correctly?

A. Yes.

Q. Did you review this medical record before concluding that Mrs. Zayre-Brown does not have severe mental distress or impairment?

A. Yes.

Q. You can set that to the side. I'm done with that document. Can someone be close with their family members and still experience significant distress?

A. Yes.

Q. You note that Mrs. Zayre-Brown doesn't suffer from distress because she worked in the commissary. Are you aware of whether that employment ended in 2020?

MR. RODRIGUEZ: Objection. Mischaracterization of testimony. You can answer.

THE WITNESS: I don't know the specific reason, if she asked to terminate her employment or if it was because of her disciplinary. But the review of these documents does recall and refresh my memory that all of these threats of self-harming her phallus were conditional.

MS. MAFFETORE: I'm going to object to that answer as non-responsive because I asked you whether or not the employment at the commissary ended in 2020.

MR. RODRIGUEZ: And he answered that and then he was proceeding to discuss the exhibits that you just gave him to.

MS. MAFFETORE: I asked if he reviewed them. That was my question.

MR. RODRIGUEZ: Right.

MS. MAFFETORE: Right.

THE WITNESS: So what I was answering was that

she had received a major disciplinary case and was placed in restrictive housing because she assaulted a peer who had allegedly teased her about her phallus or made some statement about her phallus. So all of these suicidal or talk of self-harm to her phallus were all conditional. The first set that you showed me had to do with she was facing restrictive housing disciplinary status --

MS. MAFFETORE: I'm just once again going to object to this as nonresponsive. Your counsel will have opportunity to ask you follow-up questions, if he wishes. But I have a limited amount of time with you today, so I need you to be responsive to the questions that I'm asking.

MR. RODRIGUEZ: Hold on, Dr. Penn. So he answered the question --

MS. MAFFETORE: Should we go off the record for a second?

MR. RODRIGUEZ: No. No. We're going to stay on the record. He answered your question and now he's giving some testimony about the documents that you gave to him.

MS. MAFFETORE: Right. But I didn't ask him any other questions about the documents that he gave to me. If you would like to ask him questions about those documents you're more than welcome to.

MR. RODRIGUEZ: Oh, I know that I can ask questions. But are you telling him that you would no longer

like for him to speak about the exhibits that you gave to him?

MS. MAFFETORE: If I have follow-up questions about the exhibits I would be very happy for him to answer those questions.

MR. RODRIGUEZ: Fair enough. So we'll let her ask her next question and then you can answer.

BY MS. MAFFETORE:

Q. Can someone pursue educational opportunities and still be experiencing significant distress?

A. Yes.

Q. In your opinion, is Mrs. Zayre-Brown considered stable?

A. So I have to clarify my response to answer your question. And in my -- what was the question again?

Q. In your opinion, is Mrs. Zayre-Brown considered stable?

A. Yes. Because all of these were conditional suicidal statements of self-harm, putting a rubber band around her phallus because she was unhappy with the delay in getting referred to the surgeon, and then two, the other situation had to do with she was facing restrictive housing. It probably had an affect on her maybe losing her job, her employment, but she was hopeful and future oriented. In the documents you presented to me she talks about working in cosmetology, talking about losing weight to meet the criteria for the surgery, and

other things that were hopeful and future oriented. So yeah, I mean, anything is possible. But based on my review of these documents, to answer your question, Ms. Brown was stable, clinically stable.

Q. In your opinion, does Mrs. Zayre-Brown have any comorbid medical conditions or mental health conditions rather?

A. In my opinion, yes.

Q. And what is that based on?

A. So again, I requested the opportunity to perform an evaluation of Ms. Brown and that was declined or refused. But based on my video review -- sorry, my review of the videotaped deposition Mr. Rodriguez performed and the transcript, based on review of all the medical records and prison records, based on my review of Dr. Boyd's evaluation, based on -- and testing, based on my review of Dr. Ettner's report and records, Ms. Brown potentially has -- I can't definitively say, but she probably has significant trauma from childhood neglect and abuse because she had been raised in foster care. I think her mom was 13 when she gave birth to her. She was pretty much estranged from her mother, was put into Child Protective Services, had been in the Department of Public Safety for juvenile offending behaviors for I think five years. So she clearly had a trauma history. There's some allegations or -- sorry, not allegations. There are some references in records to possible [redacted] So I don't have enough as we sit

here today to say definitively she has PTSD, but she definitely has features that are strongly suggestive of past trauma, abuse and neglect. There's also -- I can't remember. I believe Dr. Boyd on some of her testing there's the possibility of bipolar disorder symptoms or traits, and similarly there's a possibility of some antisocial versus borderline personality traits. And then from a medical perspective I understand the main issue is she's obese. She's overweight. I don't recall any other chronic medical diseases. And I think that's it.

Q. Is it your opinion that any comorbid condition from which Mrs. Zayre-Brown suffers is not well controlled?

A. What I would say is when Mrs. Brown doesn't get -- doesn't get or perceive to get what she thinks she should or is entitled to, she reacts very impulsively and puts herself at risk and that is strongly suggestive of a personality disorder and untreated trauma. I would say her comorbid complaints are stable at present but could definitely -- she definitely could benefit from additional counseling and therapy. It appears, in my opinion, that she has been focused a hundred percent on her gender surgery to the exclusion of seeking counseling or therapy to deal with impulse control, affect regulation, dealing with bad news or when things don't go her way impulse control, making better choices, social skills training, how to deal with individuals who might misgender her or make negative comments about her genitalia. So those are definite treatment

services that she would benefit from that would further help her achieve clinical -- further clinical stability.

Q. What is your understanding of whether under the WPATH standards an individual needs to be considered stable in order to be a candidate for gender-affirming surgery?

A. I'm not sure if there's language about stable. What I understand, the WPATH has changed. WPATH SOC 7 used to have a requirement that there had to be two, either psychologist and/or psychiatrist, or two psychiatrists or two psychologists, but they had to be both doctoral level and they had to essentially clear the individual and say there was no mental health contraindication to surgery. I understand in WPATH SOC 8 that that's been reduced. And I think now it's not necessarily a clearance or do they have the capacity for the surgery or there are not any mental health contraindications, but it's more of a referral. If a referring treating source mental health clinician refers -- I think only one letter is needed now and I could be wrong on that. But that's what my understanding of the new WPATH is. It's less prescriptive about the two evaluations done by doctoral level mental health staff.

Q. Is your understanding that someone needs to ascertain that an individual's comorbid mental health conditions are sufficiently under control for them to be a candidate for surgery?

A. I would say that's fair.

Q. On page 32 of your report, Exhibit-1. You note the lack of such indications of distress in a patient's medical chart is an important consideration when determining whether a given intervention is medically necessary. This is because if there is reason to believe that the intervention is necessary to prevent, and will be effective at ameliorating, such severe distress, harm, or disability, then the intervention might be said to be medically necessary.

Did I read that correctly?

A. I would say yes. But the sentence in front of that has to be read in conjunction with that last sentence that you said about that my review of Mrs. Kanautica Brown's medical records demonstrate that whatever distress she may have had as a result of her gender dysphoria, it was and is well managed, not severe, and is not causing any impairments to her daily living activities in a correctional setting.

Q. How frequently do you believe gender-affirming surgery has been ineffective in ameliorating gender dysphoria?

MR. RODRIGUEZ: Objection.

BY MS. MAFFETORE:

Q. Based on your expertise.

MR. RODRIGUEZ: Same objection. You can answer.

THE WITNESS: So my review of the Dhejnee

article -- I think it's D-h-e-j-n-e-e -- is that in that study -- it's the only study that I'm aware of that was published longitudinally looking at individuals who have undergone gender-affirming genital surgery -- had mixed results. And in fact some individuals engaged and completed suicide and others had other similar types of distress and I believe there was some regret. Some individuals recounted regret in having undergone the surgery. So to the best of my knowledge, based on my literature review, and I think Dr. Li also referenced that in her report, there is that real risk of the surgery not necessarily being curative or helpful and actually potentially being harmful.

Q. So I asked you how frequently do you believe that gender-affirming surgery has been ineffective at ameliorating gender dysphoria?

MR. RODRIGUEZ: Same objection. Speculation. You can answer.

THE WITNESS: Because it hasn't been formally studied in a prospective, controlled manner I'm not able to answer your question. I would say it's highly variable.

BY MS. MAFFETORE:

Q. Do you have reason to believe that gender-affirming surgery would be ineffective in ameliorating Mrs. Zayre-Brown's gender dysphoria?

A. My testimony would be that Mrs. Brown has some other

chronic mental health conditions. I mentioned the trauma, possible PTSD, possible personality disorder that the surgery will not do anything to correct or ameliorate. So it's possible that the surgery might help her gender dysphoria, but the other conditions will likely -- the surgery doesn't address or treat any of those other primary mental disorders, in my opinion.

Q. And so my question was do you have any reason to believe gender-affirming surgery would be ineffective in ameliorating specifically Ms. Zayre-Brown's gender dysphoria?

MR. RODRIGUEZ: Asked and answered. You can answer.

THE WITNESS: So I would say, as I testified to earlier, her whole focus to date has now been on the gender dysphoria and on the surgery. That's her whole life. In fact, as I understand it, she is -- there's some media coverage. There's some -- which is an additional stressor. At this point, as we sit here today, in my professional opinion, it's not -- it is not clear or definitive that she would -- that her gender dysphoria would be completely ameliorated by the surgery because there's other physical findings that she presents with that the gender genital surgery would not address.

Q. What are those findings?

A. Her physical presentation. She has several secondary sex characteristics, her body frame, her body appearance, her

habitus, her voice, her jawline, jaw structure, the breadth of her shoulders, her hand size, her size in general. I could go on and on, but there's multiple physical features that whether she has the surgery or not, people are probably going to continue to misgender her. And she has identified herself, repeatedly she stated that her biggest fear is that somebody will misgender her and whether she has a phallus or not. It's my professional opinion that she will likely continue to probably be misgendered, whether she has the surgery or not. And will then continue to demonstrate gender dysphoria, in my professional opinion.

Q. In any of the records that you reviewed did Mrs. Zayre-Brown identify her voice as a source of gender dysphoria?

A. I don't recall.

Q. In any of the records that you reviewed did Mrs. Zayre-Brown identify her height as a source of her gender dysphoria?

A. I don't recall.

Q. In any of the records that you reviewed did Mrs. Zayre-Brown identify the size of her hands as a source of her gender dysphoria?

A. I don't recall.

Q. In any of the records that you reviewed did Mrs. Zayre-Brown identify the width of her shoulders as a source of her gender dysphoria?

A. Not that I recall.

Q. In any of the records that you reviewed did Mrs. Zayre-Brown identify any physical feature other than her genitals as a source of her gender dysphoria?

A. Well, she has had -- she reported and I saw that in her medical chart, she's had multiple surgeries to date. A breast augmentation, fillers, body contouring, she had some chin procedure I can't recall the name of. She's had multiple surgeries, but I don't recall in the health care records or other records that I reviewed if she reported any other distress from any of those past surgeries. Sorry, I -- I'm trying to -- I thought I recalled that she did have distress from one of the surgeries. Yes, when she had the orchiectomy, the removal of the testicles, she experienced some postsurgical complications according to the medical chart, even though she was in the prison system and they were giving her wound care and dressings. I recall that she had pain and distress from that.

Q. So now I'll just reiterate that my question was other than her genitalia.

A. To the best of my recollection I don't recall any other distress from body appearance or both features in the records that I reviewed.

Q. Okay. Thank you. Are you aware of whether Dr. Boyd testified that surgery would be psychologically beneficial for

Mrs. Zayre-Brown in the treatment of her gender dysphoria?

A. I don't recall.

Q. Do you agree with Dr. Boyd that surgery would be psychologically beneficial to Mrs. Zayre-Brown in the treatment of her gender dysphoria?

A. I can't answer that yes or no because there's a risk that she might have a serious complication from the anesthesia or surgery and whether the surgery is successful or not, she could have significant complications. And it could worsen her overall life with or without affecting her gender dysphoria.

Q. So in your opinion, what are the risks of Kanautica specifically undergoing surgery?

A. Well, there's a laundry list. I would be happy to refer to Dr. Figler's evaluation where he lists them. But as I understand, and again, I'm not a surgeon or anesthesiologist, but there's a risk of death, heart attack, pneumonia, infection, paralysis, scarring, compartment syndrome. There's a term called cosmesis or something to that effect where one is not happy with the surgical -- their perception of how it's going to turn out doesn't match with how it turns out. And there's several other complications. Nerve injury. I used paralysis earlier. Fistula. There's a risk of hair is in the vaginal cavity. That could be problematic.

Q. Is your understanding that the procedure that Mrs. Zayre-Brown is seeking would create a vaginal cavity?

A. What I understand is she's seeking a vulvoplasty, but originally had been thinking of a vaginoplasty. But that's a whole separate issue because there's still ambivalence about what surgery would be best for her. According to Dr. Figler's report or his note there was some question about which would be appropriate for her. I am not a surgeon. I can't speak to this, but I believe that either when the vulvoplasty or vaginoplasty -- there's a risk of hair cells being in the vulva -- sorry, in the vaginal canal and that could cause problems. So the point I'm trying to make -- I'm getting away from the main things, infection, death, scarring, disfigurement. Those are all real conditions of anesthesia, to include death from cardiac arrythmia. Ms. Kanautica Brown is obese. She could have surgical complications for her weight. Pneumonia. So there's a laundry list of risks of surgery.

Q. Are the risks that you just identified unique to gender-affirming surgery?

A. I believe there are several risks that are specialized to gender-affirming surgery, but they also would apply to any kind of general anesthesia or alternatively being placed into the lithotomy position for extended periods of time. And I understand from Dr. Figler's note that she would have to be in that position for several hours to undergo the surgery.

Q. So you stated that Mrs. Zayre-Brown's weight is a concern. Are you aware of whether Mrs. Zayre-Brown was

required to lose a certain amount of weight in order to be considered a candidate for surgery by Dr. Figler's office?

A. Yes.

Q. Are you aware of whether she lost that weight?

A. I recall that she had lost -- I think she went from 275 to 240. But the videos that I reviewed both of the deposition and of the interview with Dr. Boyd -- again, I'm not trying to be insensitive, but Ms. Brown appeared obese, in my training as a physician. So I didn't see anywhere where a recent weight had been recorded. So I don't know her weight status as of today or the last week or so.

Q. Are you aware of whether at the time that the DTARC denied Mrs. Zayre-Brown's surgery whether or not she had achieved the weight goal set forth by Dr. Figler's office for her to receive the surgery?

A. I don't recall if they made a determination of that. I think she had dropped down to like 245. But whether that met their criteria, I don't recall, as we sit here today.

Q. If Mrs. Zayre-Brown had achieved the weight recommended by Dr. Figler's office to make her a candidate for surgery, do you have any other reason to believe that she is at high risk for complications for surgery?

A. Yes.

Q. What are those reasons?

A. Well -- and I already listed it earlier and I think

you interrupted me. I said she had a complication before when she had her orchiectomy. It didn't heal well and she had some pain. The wound dehisced, it spread. And so the best predictor of past is future -- I'm sorry, the best predictor of future is the past. Sorry, I got that backwards. So she has had a history of postsurgery complications and healing. Anyone is subject to surgical risks regardless of one's weight. Everyone theoretically could have risk from general anesthesia and surgery.

Q. In your opinion, is there any risk of Mrs. Zayre-Brown regretting the procedure?

A. Certainly.

Q. What is your basis for that opinion?

A. Well, it's based on the Dhejnee article that I mentioned earlier that the literature is limited, but the one study that shows longitudinal followup of individuals that have had the type of surgery that Mrs. Brown is seeking, there was some patients that experience complications and -- and I have read of other articles by urology -- in urology journals that describe the risks of complications with the surgery also.

Q. What specific to Mrs. Zayre-Brown's circumstances lead you to believe that she is at risk of regretting the procedure?

A. Because she's the only one that -- when she -- if and when the phallus is removed, she will be the only one that can identify that she no longer has a phallus. She still appears

typically as a male -- sorry, transgendered female. But she still has several secondary sex characteristics that would suggest her being transgendered. So in my professional opinion having genital surgery is not going to cure all of her gender dysphoria. Plus, she has the comorbid likely mental health conditions that I described earlier, that I testified to earlier.

Q. What risk, if any, do you think there is that Mrs. Zayre-Brown's gender dysphoria will worsen if she is not provided gender-affirming surgery before her release date?

A. Anything is possible. She has stated that she's put a rubber band around her phallus. She stated that she plans to scratch or rub the skin off her phallus. So it's possible that she could develop a skin infection, or alternatively, if she does in fact amputate or auto amputate her phallus, that could occur. So there are some risks that she will further attempt to self-harm her genitalia. That's fair.

Q. In your opinion, do you think Mrs. Zayre-Brown's gender dysphoria will improve if she is not given gender-affirming surgery, if she retains her phallus?

A. What I would testify to is that she is totally a hundred percent focused on this one surgery to the neglect of her other lifelong issues. I would say I don't currently have an opinion because my opinion is guarded without -- without knowing that she is making an effort to begin to work on her

other trauma and abuse and neglect issues and relational issues, in my professional opinion, my opinion is guarded. I don't have an opinion regarding what the surgery or not having the surgery, what impact it would have on her gender dysphoria.

Q. Understood.

MS. MAFFETORE: Can we go off the record for just one second?

- - -

(Discussion held off the record, 4:13 p.m. 4:13 p.m.)

- - -

BY MS. MAFFETORE:

Q. I would now like to look at your report, Exhibit-1 at page 33. So you state on page 33 at the top it is my opinion, based on my education, training, and experience, that there is a lack of high-quality scientific and medical literature indicating the long-term efficacy of gender-affirming surgery as a treatment for gender dysphoria.

Did I read that correctly?

A. Yes.

Q. Are you holding yourself out as an expert in the quality of scientific evidence in this case?

A. No.

Q. Are you holding yourself out as an expert in statistical methodology in this case?

A. No.

Q. Study design?

A. No.

Q. Biostatistics?

A. No.

Q. Bioethics?

A. No.

Q. Further down on page 33 in a sentence beginning with moreover you note that the studies pertaining to gender-affirming surgery suffer from many basic design problems, such as small sample sizes, lack of baseline psychological testing to identify baseline and pre-existing mental disorders and personality disorders in particular, lack of baselines and outcome measures, lack of validated measures, lack of a control group, lack of multiple sizes, lack of standardization for controlling outside variables, various relational and psychosocial stressors, substance abuse, and other conflicts unrelated to the surgery, sample bias and more, correct?

A. You said substance abuse, but it's substance use.

Q. I wrote substance abuse here and said substance abuse anyway. Otherwise correct?

A. Yes.

Q. What is your understanding of whether it would be ethical to conduct a study regarding the efficacy of

gender-affirming surgery with a control group?

A. I think it could be done in a community. It might be a little more challenging in a correctional setting, but I think it could be done.

Q. What is that opinion based on?

A. Well, I was trained in research and clinical research and how to actually do research. I have published some articles and I have gotten grant funding before. I would say working as part of a team of other Ph.D.s such a study could be designed. It would be complicated and getting enough samples would be challenging, but I think it could be done.

Q. Do you think it could be done ethically?

A. Yes.

Q. A little higher up, two sentences, you say that you are generally familiar with the research referenced by the division TARC. To which research are you referring there?

A. I would have to refer to the division TARC document. I don't recall specifically -- if they're referring to Dr. Campbell's position statement or if they refer to other documents.

Q. Are you referring there to the research from Dr. Campbell's position statement?

A. I would have to review the document. I can't -- I don't know off the top of my head what I was referring to here.

Q. Understood. Are you generally familiar with the

research from Dr. Campbell's position statement?

A. I think I testified to that earlier, that there was some documents that I wouldn't necessarily hold the same weight as a peer-reviewed study like the Psychology Today and some of the other studies -- sorry, it's not a study. It's just an article. Those are just like lay press articles. I would need to be able to go through each one of these and actually read the study and look at the methodology to answer your question.

Q. So sitting here today your testimony is that you have not gone through each of these studies and looked at the methodology, is that correct?

A. I don't recall. I know Gibson V Collier is not a study. It's a case we had in Texas. It's a legal ruling. But no, I haven't -- maybe better than saying studies, these are citations. That's how they're referenced here in the article. Sorry, referenced in the position statement. Sorry.

Q. So sitting here today you have not reviewed all of the citations in this -- that are cited?

A. That's fair.

Q. Okay. What is your understanding of the comprehensiveness of Dr. Campbell's research in support of his position statement?

A. So I don't know if I would call it research. It sounds like he did a literature review and he did his own analysis of that literature review. But I wouldn't really call

it research.

Q. So that's not what you're referring to then when you say you are generally familiar with the research referenced by the division TARC?

A. I think when I'm referring to research I'm referring to like peer-reviewed articles that might have been referred to by the division TARC.

Q. Okay. What is your understanding of Dr. Campbell's qualifications to conduct research comprehensively in support of his conclusions related to Mrs. Zayre-Brown?

A. So I don't really have an opinion. All I know is Dr. Campbell is a medical director. I don't know what -- if he's a family doctor or internal medicine doctor. I don't know if he has any research background or training. So I don't really have an opinion right now.

Q. Okay. To your knowledge did Dr. Campbell refer to any studies that indicated that gender-affirming surgery may be medically necessary?

A. May be?

Q. Yes.

A. It may be? Sorry. I'd have to review the article itself. The first one, the Swedish study just -- again, it's possible that that study showed some benefit. But I would want to read the article itself to be able to answer your question.

Q. I understand. So on page 34 of your report in the

first full paragraph you also mention your own literature review. You state as Dr. Li's comprehensive report demonstrates, and as the literature review of Dr. Campbell (see DAC 3412) and that of my own (see DE-18-8) indicates, there is a lack of high-quality research on the topic of the long-term efficacy of gender-affirming surgery in treating gender dysphoria. Is that correct?

A. Yes.

Q. And just to close the loop on this. Is DAC 3412 the bates number on the position statement that we were just discussing on the bottom right-hand corner? Exhibit-8.

A. I'm sorry, say that again.

Q. Exhibit-8, is the number on the bottom right-hand corner of Exhibit-8 DAC3412? On the first page.

A. 3412?

Q. On the first page, bottom right-hand corner underneath your exhibit sticker.

A. 3404.

Q. 3404. Okay. What is the page number on the last page?

A. 3415.

Q. So does 3412 fall somewhere within this document that we were just discussing Dr. Campbell's position statement?

A. Yes, 3412 -- so he refers to on 3412 evidence-based peer-reviewed medical studies free from bias or conflict of

interest, leading to near consensus among the medical community, and it goes on and on. But that's what I'm referring to here.

Q. Okay. But you also refer to your own literature review and you point us to a document DE-18-8.

MS. MAFFETORE: I'd like now to hand to the court reporter document DE-18-8, which was your affidavit that you filed in support of defendant's opposition to plaintiff's motion for summary judgement.

- - -

(Document marked as Exhibit-14 for identification.)

- - -

BY MS. MAFFETORE:

Q. So you refer us to paragraphs 53 through 60 in your affidavit as your literature review, is that correct?

A. Yes.

Q. So turning first to page -- or to paragraph 53. So you note that in searching for literature regarding surgical intervention as the treatment for gender dysphoria in the correctional setting you input the following search terms: "Gender-affirming surgery (GAS)", and "corrections", "correctional settings", "incarcerated patients", "incarcerated individuals ", correct?

A. Yes.

Q. Putting terms in quotation marks requires the search yield that complete and exact term, correct?

A. I believe so.

Q. So a search for open quotation marks, gender hyphen affirming surgery, parentheses, GAS, close parentheses quotation marks would not yield just gender hyphen affirming surgery, correct?

A. I haven't done one of these in a while. I do them fairly often. But that's kind of how I was taught when I did my research, clinical research methodology both during my adult psychiatry training and also my child psychiatry training.

Q. Okay. And so a search for gender -- open quotation marks, gender hyphen affirming surgery, parentheses, GAS, close parentheses, would also not yield a search result for gender confirmation surgery, correct?

A. I mean, it's possible if you put -- because of gender surgery you might get a match because there's two words and maybe not the third word. I would have to do it actually to test that.

Q. But your understanding is that, again, using quotation marks requires that the search yield a complete and exact term?

A. I don't know. I mean, I think the PubMed is actually pretty -- sometimes I'll actually mistype something and it will pull something up. So as we sit here today I can't be definitive yes or no, it does or it doesn't.

Q. Did you utilize any other search terms that aren't provided here?

A. I don't believe so, but I have done this kind of search -- it wasn't like a one-time and that's it. I have done it numerous times over the last 10 years.

Q. You did not search for the word prison or prisoner in your search?

A. I don't believe so.

Q. Do you have confidence that the search you ran provided for the most comprehensive possible search results?

A. I would say generally, yes. I mean, it's possible that some esoteric journal, you know, some non-U.S. or non-United Kingdom or non-Swedish study could pop up.

Q. You then note at paragraph 54 of your affidavit, Exhibit-14, that you reviewed the available literature concerning the effectiveness of surgery as an intervention in the community, correct?

A. Yes.

Q. How did you go about conducting that review?

A. I believe -- and I probably should have written it. I believe I looked at WPATH, what the studies -- and that's how I came to the study that I cite in 55 below and 56. Because those were community studies, as I testified to earlier. There's not been any correctional studies. Most of the studies that have been done have been in like Sweden or I think Denmark

and maybe Belgium, as I recall.

Q. Did you utilize any search terms to conduct your own independent search?

A. And I'm so sorry, Holland or Amsterdam was the other one. Sorry. I apologize. Say that again, please.

Q. Did you utilize any search terms to conduct your own independent search?

A. I mean, it's possible. Like I said, I have done several of these before. But that's generally how I do it, looking for gender-affirming surgery, genital surgery. I think I may have used sexual reassignment surgery in the past also.

Q. Do you have confidence that your review was comprehensive?

A. I mean, anything is possible and that's why I defer to Dr. Li because she's actually a Ph.D. in comparative research effectiveness and has dedicated her life. And so I probably have more -- I feel like I have done my due diligence as a practicing, you know, psychiatrist. But I think Dr. Li is obviously much more qualified and so I would put more weight on her studies.

Q. At the time that you submitted this affidavit, had you reviewed Dr. Li's --

A. No. And that's a great question. Dr. Li, as I understand it, had not been retained or disclosed as an expert until recently. I think this year, maybe the spring of this

year. So I prepared this affidavit based on information available to me at that period in time and now, as we sit here today, my opinion is strengthened based on -- aside from my previous reviews, but from what Dr. Li has done and her exhaustive review.

Q. So speaking specifically about the literature review that you conducted to support your affidavit and subsequently your report, you mentioned only two studies in what you have called your review of the literature, correct? The reduction in mental health treatment, utilization among transgendered individuals after gender-affirming surgery, a total population study. And then later, long-term followup of transsexual persons undergoing sex reassignment surgery, cohort study in Sweden, is that correct?

A. Yes.

Q. Why did you opt to only include those two studies to support your conclusion that the existing research is conflicting and limited?

A. Those were the two studies that I found that met the criteria for the search engine that I utilized.

Q. So in footnote 10, which is on page 27, you state the studies noted herein are not intended to be exhaustive but only representative. There are multiple other studies on the topic that reach conflicting conclusions, correct?

A. Yes.

Q. Did you review other studies that reached conflicting conclusions?

A. Sorry, I'm looking for where 10 -- the footnote is --

Q. Page 27 at the very bottom.

A. Yes. I looked at the Dhejnee study that I've testified to earlier and I was very surprised when I read the Branstrom study that that actually had to be redacted. They had to publish a redaction. Specifically the Branstrom, B-r-a-n-s-t-r-o-m, his group had to publish a redaction in the American Journal of Psychiatry because they had received a lot of criticism that they had over generalized their findings and they had to publicly redact and say we overstated our findings and the generalized ability of her findings and results. And so anyway, I looked at those.

Q. Right. So the question I asked you was did you review other studies other than the two that you explicitly mentioned in your affidavit?

A. Yes.

Q. Which ones?

A. Well, I don't recall. But they're the ones that I tried to search when I use that search engine in the PubMed in gender-affirming surgery.

Q. Did you generate a complete list of all of the sources that you reviewed in your literature review to come to the conclusion that there are multiple studies on the topic that

reach conflicting conclusions?

A. No, I did not.

Q. Why didn't you provide a list?

A. One, I wasn't asked to do that. Two, the time frame. I think there was a deadline for this report. Three, sure, now looking at Dr. Li's I can see that probably I could do a better job with it. This is, again, not my area of expertise. So again, I defer to Dr. Li and I -- her results strengthen my opinions on these topics.

Q. Do you feel confident that you interpreted the studies that you did correctly?

A. Yes.

Q. Do you feel that you interpreted them consistently with the intent to the authors?

MR. RODRIGUEZ: Objection, speculation. You can answer.

THE WITNESS: I'm sorry, what was the question again?

BY MS. MAFFETORE:

Q. Do you feel that you have interpreted them consistent with the intent of the authors?

MR. RODRIGUEZ: Objection, speculation. You can answer.

THE WITNESS: I have no idea what the intent of the authors was or were. I did read, you know, the title of

the article, the abstract, the data, the findings, the results the methodology and all that, but I don't know what the intent of the authors were.

BY MS. MAFFETORE:

Q. Understood.

MS. MAFFETORE: I would now like to hand you what the court reporter will mark as Exhibit-15.

- - -

(Document marked as Exhibit-15 for identification.)

- - -

BY MS. MAFFETORE:

Q. I will represent to you that Exhibit-15 is a compilation of documents that were provided to us by your counsel in response to a subpoena that was issued to you.

Do you recognize Exhibit-15?

A. Is there a way to redact my phone number on here?

MR. RODRIGUEZ: There is. I didn't catch that. Yes.

MS. MAFFETORE: I will not be reading your phone number into the record, just for your peace of mind.

THE WITNESS: The answer to your question, yes, I do recognize this.

BY MS. MAFFETORE:

Q. Great.

A. Yes.

Q. Okay. So I would like to ask you specifically about the pages marked Penn 10 and Penn 11 of Exhibit-15.

A. Okay.

Q. So what is this page, Penn 10?

A. This is an invoice.

Q. And is this invoice for work done in the case of Kanautica Zayre-Brown?

A. Yes.

Q. And was this work performed or related to the affidavit that you filed in this case?

A. Well, it's -- it pretty much speaks for itself. It's dated February 9, 2023 and it goes through from June 9, 2022 and lists affidavit drafting and edits and whatnot, and it goes all the way up through February 3, 2023.

Q. So at the bottom of Penn 10 there is -- the very last entry. It's dated 7/17/22 and is states literature review/research and the hours listed there are 2.5. Two-and-a-half hours, is that correct?

A. Yes.

Q. And then on the next page, the next entry on 7/18 states declaration edits and additional literature review, 3.5 hours or three-and-a-half hours, is that correct?

A. Yes.

Q. And none of the other entries on this invoice mention

research or literature review, is that correct?

A. That's fair.

Q. So is it fair to say that you spent some amount of time, between two-and-a-half and five-and-a-half hours, conducting your research and literature review in this case?

A. Specific to this case, yes. But as I testified to earlier, in my work on the gender dysphoria -- sorry, on the joint gender dysphoria work group I have had to review this literature previously. So I was basically looking to see if any new articles had come up and review of existing articles that I previously had pulled and looked at.

Q. And in your experience is two-and-a-half to five-and-a-half hours a sufficient time to conduct a thorough and comprehensive literature review?

A. Yes.

Q. You testified previously that you felt that Dr. Li's report demonstrated that you could have done a more thorough job, is that accurate?

A. Yes.

Q. Did you review those studies that Dr. Li cited in conjunction with her literature review in the preparation of your expert report?

A. Yes.

Q. Did you review all of the sources that Dr. Li cited in preparation for your expert report?

A. I believe I looked at the abstract, but I don't believe I read the entire article in its entirety. But I did look at the abstracts, yes.

Q. How many articles would you say that you read in their entirety?

A. I don't know. I would have to refer Dr. Li's reports and her graphs -- or tables rather. But I would say I pretty much reviewed them all.

Q. The abstract?

A. Yes.

Q. What is an abstract?

A. The abstract is kind of like the description of the problem or issue, what they sought to study, the methodology, the data, and then the results or conclusions. That's kind of what the abstract is. It's kind of like a Cliffs Notes version to the entire article.

Q. On average, how long would you say an abstract is, generally speaking?

A. It varies. It could be a couple hundred words or more.

Q. So generally a couple hundred words?

A. Uh-huh.

Q. Sticking with your affidavit or going back to your affidavit rather, which was Exhibit-14. I'd like to discuss with you some other things that you included in your affidavit.

So starting on page 12, paragraph 35. This is under a heading titled Unique Considerations in the Correctional Setting. And paragraph 35 you note that the correctional setting is different than the community is obvious. However, there are a host of considerations regarding the delivery of health care, in general, and in particular the management of transgender health care in the correctional setting which are not so obvious.

Did I read that correctly?

A. Yes.

Q. Turning then to paragraph 37. You note, for example, in the community, a person's legal or criminal history is not factored into an analysis of whether to proceed with a particular intervention, or even whether certain decisions are even considered interventions. That is not the same in the correctional context.

Did I read that correctly?

A. Yes.

Q. Is it your opinion that Mrs. Zayre-Brown's legal or criminal history is relevant to determining whether gender-affirming surgery is medically necessary to treat her gender dysphoria?

A. Yes.

Q. In what way?

A. So I don't recall that she ever had a history of

sexual offending. And she's done very well, to the best of my knowledge, other than that one altercation where she seriously injured her -- one of her -- another inmate that had to go offsite to an emergency room. But other than that, I don't recall any types of sexual offending behaviors. But that would be an important issue if you were going to move a -- say a transgender -- a trans female into a female facility and they had a history of being a serial rapist or a sex offender, or sexually violent predator. So that's an example of why it would be important to look at their legal history.

Q. Okay. So I'm asking you not for an example, but specifically as to Mrs. Zayre-Brown, is her legal or criminal history relevant to determining whether gender-affirming surgery is medically necessary?

A. I would say it would be one part of her biopsychosocial history to consider, but it wouldn't be the ultimate decision-making variable or factor.

Q. What is your understanding of whether Mrs. Zayre-Brown's legal or criminal history was relevant to the North Carolina Department of Public Safety's determination that gender-affirming surgery was not medically necessary for her?

A. I don't recall at any of the facility TARC -- T-A-R-C or the division TARC, that her legal history was -- other than just factual, what she was incarcerated for, I don't recall it weighing into the decision-making, as I recall.

Q. On page 14, paragraph 39, you also note custody, housing and classification determinations and other custody-related considerations, that are unique to the correctional setting, must also be seriously considered with regard to any other interventions, including medical, hormonal treatments, and/or surgical interventions. And then you go on to state surgical considerations include, but are not limited to, the psychiatric/mental health stability of the patient, the availability of qualified in-state surgeons with particular knowledge and expertise in performing various surgeries for transgender individuals and who are comfortable and are willing to provide surgery to incarcerated individuals, rates of patient acceptance and satisfaction with the particular proposed surgeon or surgical practice, effectiveness of alternative nonsurgical intervention, short and long term clinical outcomes, risks of anesthesia and surgery and post-surgical complications, potential benefits versus the patient's perception of harm from postponing the procedure, until it can be performed in the community, preoperative procedures, postoperative care, costs of the procedure, attainment of fully informed consent, e.g., the patient's ability to weigh the various risks, benefits, alternatives and provide truly voluntary informed consent and more.

Did I read that correctly?

A. Yes.

Q. Is it your position that these considerations are unique to the correctional setting?

A. Some of those are. For example, the issue of qualified in-state that would be willing to do that for an incarcerated individual. And then two, the hospital willing to have correctional officers, you know, there either in the operating suite and/or the post -- you know, the recovery room and then in the postsurgical suites and in the regular rooms. I would say that's definitely different. What I would say is there's probably a perception by inmates that they're not getting the best surgeons. They're getting kind of like the people that are not the A-team, but maybe the B- or C-team. And so -- and maybe a resident or fellow, as opposed to an attending. So that certainly could happen in a correctional setting.

Q. Are you aware --

A. Sorry. I was looking through all this. Sorry. The issue of postponing the procedure, obviously that could be postponed in the community too. But in a correctional setting, a release date, that's a big deal and it's been my experience that some inmates will decline a variety of surgeries or medical interventions and they'll say I'll get that done when I get out because of the hassle or perceived hassle. And then I think I've testified to this earlier, the issue of fully informed consent in a correctional setting because it's

inherently coercive. You really have to ascertain that the patient is able to give full informed -- voluntary informed consent. I think that's it.

Q. Are you aware that there is an in-state provider for vulvoplasty who had already consented to perform the procedure on Mrs. Zayre-Brown?

A. I'm aware that there is a faculty member, Dr. Figler. But as I recall there was some -- what I understand from the note that Dr. Figler wrote, there was some confusion or discrepancy whether vulvoplasty or vaginoplasty was the preferred -- or recommendation for Mrs. Brown. That's what I recall from the note.

Q. Okay. And so are you aware that there is an in-state provider of vulvoplasty and vaginoplasty who had already consented to perform a gender-affirming surgical procedure for Mrs. Zayre-Brown?

A. That's not what I understand according to the documents. What I understand is that Dr. Figler was asked to assess if she was a surgical candidate. Dr. Figler wouldn't be able to or wouldn't be authorized to do the surgery with North Carolina Department of Adult Corrections's funding unless -- until it was subsequently reviewed by the FTARC, the DTARC, and then finally the last two individuals that I testified to earlier. So I don't -- to clarify, Dr. Figler, as I understand it, did not determine or did not say this was medically

indicated or medically necessary. He simply said that Mrs. Brown was a potential candidate for the surgery.

Q. Nevertheless, Dr. Figler is a qualified physician in state who if approved was willing to provide surgery to an incarcerated patient, is that correct?

A. I don't know Dr. Figler's qualifications or his background so I'm not prepared to testify if he's qualified. I would need to know how you define qualified. I mean, he's probably a very good surgeon, but as we sit here today without me knowing his medical board, how many lawsuits he has against him, if he's ever been reprimanded by the medical board, if he has any peer issues or issues within his department, as we sit here today I'm not prepared to say yes, he's a qualified person to do this.

Q. Understood. To what extent did you consider the effectiveness of alternative nonsurgical interventions in treating Ms. Zayre-Brown's gender dysphoria?

A. I did consider that and it's my understanding that she has had an orchiectomy and that she's currently on hormone -- gender-affirming hormone treatment. And it appears again that she's not manifesting any current emotional distress, pain or suffering, and is certainly not engaging in any self-harm in the last two years.

Q. So is it your opinion that the interventions that she has already undergone have cured her gender dysphoria?

A. No, that's not my opinion. My opinion is that her gender dysphoria is currently stable because she's had the orchiectomy, she's had the ability to move to a female facility where she's been for several years in spite of being assaultive and a major assault. My experience is that some custody staff might have moved her back or moved her into -- given her history. But no, she's doing very well. I'm not aware of any -- if you have them, I would love to look at them, but any recent self-harm, threats of self-harm, threats to hurt her genitalia for the last two years. I'm not aware of any -- other than her exclusive focus on this surgery. That appears to what -- her whole life is focused in on right now.

Q. Understood. You mentioned informed consent as one of the things that requires special consideration in the correctional context. Do you have any reason to believe that Mrs. Zayre-Brown cannot provide informed consent to receive gender-affirming surgery?

A. Yes.

Q. What is that reason?

A. Well, the concern I have, and Dr. Boyd flushed this out more, is that I think both Dr. -- sorry, your expert. I'm blanking on her name. Dr. --

Q. Dr. Ettner?

A. Thank you. Dr. Ettner. It's like cause and effect. If she has the surgery she's going to be magically cured -- and

I'm sorry, I don't mean to be -- she will be cured or improved from her gender dysphoria. But I think Dr. Boyd, and I do agree with this, that the trauma, abuse and neglect that she's had in the past as a child and adolescent will not be cured by any gender-affirming surgery and is clinically important. And I think I testified to this earlier, she will benefit from psychotherapy to help her with misgendering and with individuals either in the correctional setting or in the community who provoke her or set her off by making negative comments about her appearance or her genitalia or what have you. So that's my opinion.

Q. Are you aware of whether Dr. Boyd ultimately concluded that Mrs. Zayre-Brown has the capacity to provide informed consent?

A. I believe I recall that, yes.

Q. Do you recall whether Dr. Boyd ultimately concluded that while she might -- Mrs. Zayre-Brown might have some co-occuring conditions they were not so active or occurring as to distort her ability to make decisions?

A. That's fair, yes.

Q. Turning then to paragraph 44 of your declaration which is on page 19. You state correctional systems must assess the costs of approving various medical and other health care interventions for any disease state. And then you go on to say at the very end of this paragraph, which is on the next page,

thus, a correctional agency, like the Department, must utilize its dollars in a way that allows it to provide for the health care needs of all persons in its care and custody most efficiently and fairly.

Did I read that correctly?

A. Yes.

Q. Is it your opinion that the cost of surgery is relevant to determining whether gender-affirming surgery is medically necessary for Mrs. Zayre-Brown?

A. No.

Q. Turning then to paragraph 46, which actually begins on the same page. Actually, never mind. We already talked about this. Paragraph 47. So at paragraph 47, which is on page 21 of Exhibit-14, you note given the plethora of considerations in assessing the appropriateness of any given surgical intervention in the correctional setting, the potential impact of postponing the procedure until it can be performed in the community must also be evaluated.

Did I read that correctly?

A. Yes.

Q. Is it your opinion that this surgery cannot be provided competently in the prison setting?

A. Can you clarify when you say competently? I'm not sure I understand what you mean by that.

Q. How would you define competently?

A. My opinion would be yes, this surgery could be performed, but my testimony would be that ideally, given her history of having complications before, she was I think a month or two out -- sorry, she was somewhere between that, one and two months from having the orchiectomy, she had complications from the orchiectomy in the prison setting and had problems and it took some time for those issues to be addressed and managed. My opinion is that the prison probably could do this and -- you know, if they found an appropriate, qualified, competent, to use your words, surgeon who could do the surgery, the question would be provided that she didn't have any significant postoperative complications, which is certainly possible, yeah, she could have this and return to her prison setting. I think that's fair.

Q. Is it your opinion that Mrs. Zayre-Brown's release date impacts the medical necessity of the surgery?

A. No.

Q. Okay. Are you aware of when Mrs. Zayre-Brown first requested surgery from NCDPS?

A. So I recall that she came in -- I don't have the exact dates. It would be a guess to the exact dates. Something tells me she came in 2012, October 2012, and then for the first year or two she was wanting her hormones. And then subsequent to that, I think it was maybe '15 was when she first asked for the surgery, but I could be wrong on that.

Q. So by your estimation Mrs. Zayre-Brown has been requesting this surgery for at least seven years?

A. That's fair.

MS. MAFFETORE: We can go off the record real quick.

- - -

(A break was taken, 4:56 p.m. - 5:05 p.m.)

- - -

MS. MAFFETORE: I just want to state for the record that we have identified that pages seven and nine of Exhibit-15 do contain general confidential information. And so for purposes of designating any exhibits as confidential, pages seven and nine contain a phone number under Dr. Penn's signature. That should be -- the parties will redact and should be treated as general confidential information.

I just have a couple of questions and then I can turn you over to counsel representing you in this deposition or we'll be done.

BY MS. MAFFETORE:

Q. You previously testified that you have reason to believe that Mrs. Zayre-Brown might regret the procedure and I believe that you testified primarily that that could be related to her surgical outcomes, is that correct?

A. Yes. And also it's possible that she doesn't get the intended effect that she thinks she's going to get. So kind of

really assessing what is she going for, what does she hope is going to happen.

Q. Do you have any reason to believe that Mrs. Zayre-Brown will regret the removal of her phallus specifically?

A. One of the complications that I read in Dr. Figler's -- he wrote -- he writes as a standard risk is the issue of urine stream and that there's a problem like -- I hate to use the term, but like dribbling. Instead of having a straight urine it's possible there could be dribbling. Sure, it's possible there may be some regret. I know that Mrs. Brown has not stated about deriving any sexual pleasure from her phallus. It's certainly possible. So yeah, as we sit here today I don't have an opinion of whether she will or will not. It's possible.

Q. Do you have any reason to believe that she will one day wish that she has a phallus based on everything that you have reviewed in this case?

A. To this date she stated how horrified and how ugly and hideous and how she wants it gone, but it's possible that there might be regret.

Q. Do you have any reason to believe that she would regret? I understand that you're saying that it's possible. Anything is possible. Do you have any reason to believe that that is the case?

A. No.

MS. MAFFETORE: I don't have any further questions.

MR. RODRIGUEZ: I don't have any questions.

MS. MAFFETORE: Okay.

- - -

(Witness excused.)

- - -

(Deposition concluded 5:08 p.m.)

- - -

CERTIFICATE OF REPORTER

STATE OF NORTH CAROLINA)

COUNTY OF ALAMANCE)

I, Susan A. Hurrey, RPR, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that the witness reserves the right to read and sign the transcript of the deposition prior to filing; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

This the 21st day of August, 2023.

_____

SUSAN A. HURREY, RPR

Notary Public #201826800211

I, JOSEPH V. PENN, M.D., do hereby state under oath that I have read the above and foregoing deposition in its entirety and that the same is a full, true and correct transcript of my testimony, subject to the attached list of corrections, if any.

_____

JOSEPH V. PENN, M.D.

STATE OF_____

COUNTY OF_____

Sworn to and subscribed before me this_____day of_____, 20_____.

_____

Notary Public

My commission expires:_____

E R R A T A S H E E T

_____ __

PAGE LINE CORRECTION

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I, _____, after having read the foregoing transcript of my deposition, wish to make the above corrections.

SIGNATURE_____

DATE_____